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SECRETARY OF THE AIR FORCE**

**AIR FORCE INSTRUCTION 41-106**

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**Health Services**

**MEDICAL READINESS PROGRAM  
MANAGEMENT**



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This Instruction implements Air Force Policy Directive (AFPD) 41-1, *Health Care Programs and Resources* and DOD Instruction (DODI) 1322.24, *Medical Readiness Training*. It sets procedures for medical readiness planning, training, exercising and reporting in support of the full spectrum of medical operations, including expeditionary, humanitarian assistance, all hazards response, global health engagement and stability operations. This Instruction applies to active component (AC) and air reserve component (ARC) units and may be supplemented at any level, but all direct Supplements must be routed to the Office of Primary Responsibility (OPR) of this publication for coordination prior to certification and approval. **Note:** The term MAJCOM, when used in this publication, refers to all Major Commands (MAJCOM), Field Operating Agencies (FOA), Direct Reporting Units (DRU), Air National Guard (ANG), and Air Force Reserve Command (AFRC) unless otherwise indicated. The authorities to waive wing/unit level requirements in this publication are identified with a Tier ("T-0, T-1, T-2, T-3") number following the compliance statement. See AFI 33-360, *Publications and Forms Management*, for a description of the authorities associated with the Tier numbers. Submit requests for waivers through the chain of command to the appropriate Tier waiver approval authority, or alternately, to the Publication OPR for non-tiered compliance items. In addition, copies of all submitted waiver documents for this Instruction will be provided to the parent MAJCOM/SGX, regardless of Tier waiver approval authority. Supplementing publications must be sent to the OPR of this Instruction for review and coordination before publication. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with Air Force Manual (AFMAN) 33-363, *Management of Records*, and disposed of in accordance with Air Force Records Disposition Schedule (RDS) located in the Air Force Records Information Management System (AFRIMS). The use of the name or mark of any specific manufacturer, commercial product, commodity, or service in this publication does not imply endorsement by

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### ***SUMMARY OF CHANGES***

This document has been substantially revised and must be completely reviewed. Significant changes include: clarification and expansion of Limited Scope and Limited Scope (LS) with Interservice Support (LSISS) military treatment facilities (MTFs); removal of the requirement to maintain a medical readiness training and exercises schedule (MRTES); streamlining of roles and responsibilities; removal of exercise and exercise evaluation team (EET) guidance covered in other AFIs; reduction and streamline of medical readiness committee (MRC) meeting agenda topics and medical contingency response plan (MCRP) required annexes to provide increased commander flexibility; removal of the requirement to maintain MCRP team chief binders and AFSC functional training manager binders; revision of medical reportable training requirements; ARC guidance formerly maintained in Chapter 10 streamlined and incorporated throughout the document; removal of “how to” guidance throughout the Instruction to the AF Medical Readiness Guide.

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## Chapter 1

### AIR FORCE MEDICAL SERVICE READINESS PROGRAM

**1.1. Mission Overview.** The Air Force Medical Service (AFMS) provides seamless health service support to AF and combatant commanders (CCDR) and assists in sustaining the performance, health and fitness of every Airman in-garrison and while deployed within the Continental United States (CONUS) or overseas (OCONUS) in support of global operations. This capability is summarized by the phrase “global medical readiness” which includes the full spectrum of medical operations (expeditionary deployment operations, humanitarian assistance, all-hazards response, and global health engagement to support building partnerships and stability operations). It also includes the necessary planning, training, and readiness support functions (reports, disaster management, and others) associated with these operations. Components of this global system are fully integrated, with forward-deployed medical support, and en route care to facilities providing comprehensive definitive medical specialty care. The foundational emphasis is on prevention of illness and injury. When illness or injury does occur, the AFMS provides a rapidly responding modular medical capability which can be tailored to meet specific requirements. If more definitive care is required, the AFMS supports an effective “evacuate and replace” policy through aeromedical evacuation (AE) of joint and combined forces. With this focus on preventive medicine, superior health care, and aeromedical evacuation, the AFMS promotes and advocates the optimization of human performance sustainment and enhancement, including the optimal integration of human capabilities with operational systems. To achieve the mission, the AFMS developed processes to support operational strategies, emergency management, medical readiness training, manpower and equipment force packaging, medical readiness resourcing, aeromedical evacuation and global medical operations plans and reporting. The following sections will introduce these areas:

**1.2. Operational Strategies.** The AFMS employs multiple planning strategies to ensure capabilities are organized, trained, equipped, and available to meet contingency requirements.

**1.2.1. Modular Capabilities.** The AFMS provides a light, lean, modularized medical capability that can be deployed rapidly to support operations overseas and at home.

**1.2.1.1.** Most initial medical support begins with either the Global Reach Laydown (GRL) team or the Squadron Medical Element (SME). The GRL UTC FFGRL consists of four personnel and is assigned to the Contingency Response Group (CRG) to provide medical support during rapid opening of contingency airfields. The purpose of the CRG is to bring significant order, foresight, speed, and safety during the critical opening days of a contingency. The SME is a small team designed to provide aerospace medicine support to an AF flying squadron. This team deploys with the squadron and provides care and initial preventive medicine surveillance. As support to the expeditionary squadron grows, the SME can be augmented with additional independent duty medical technicians (IDMTs) and a preventive aerospace medicine (PAM) team. The PAM team provides aerospace medicine support during the opening of a contingency airbase, including performing the GRL role described in this Instruction if that UTC is not tasked. If the beddown site becomes a more permanent operating site or the population at risk (PAR) increases, the AFMS can deploy the Expeditionary Medical Support (EMEDS)

system. The scalable nature of EMEDS allows the AF to deploy capabilities from small teams that can provide highly skilled medical care for a limited number of casualties, to a medical system as large as an Air Force Theater Hospital (AFTH) that can provide specialized medical care to a PAR of several thousand.

1.2.1.2. For casualties requiring more definitive care than that provided by the EMEDS, the Global Patient Movement System can provide rapid movement of patients to the appropriate level of care. As a component of the USAF Mobility Air Forces (MAF) system, AE crews provide en-route medical care to stabilized patients during transport on MAF aircraft. Critical Care Air Transport Teams (CCATTs) are used to augment AE crews to provide advanced specialty medical capability to evacuate critically ill, injured, or burned patients requiring continuous stabilization and advanced care during transport.

1.2.1.3. These modular capabilities are organized by force modules to complement increases in combat capability. As a beddown grows, predetermined support assets, including medical assets, are deployed to that beddown. These predetermined modules provide an organized expansion capability, offer predictability to the supporting units, and simplify the planning process.

1.2.1.4. In addition to missions associated with aircraft beddown locations, AFMS forces may deploy in support of stability operations to build partner nation governance and security capacity as well as provide humanitarian aid and disaster relief.

1.2.2. Capabilities-based Planning. The AF has shifted from a programs/platforms mentality to capabilities-based planning. Commanders and their planners identify requirements for specific capabilities not for units, and those capabilities are then associated with trained and available unit type codes (UTCs). In order to quantify capabilities, the Office of the Secretary of Defense (OSD) has directed that all Services observe, assess, and report their units' ability to perform through mission essential tasks (METs) measured against a specific standard.

1.2.3. AEF Teaming and Force Presentation. AFMS personnel assigned to warfighting organizations (e.g. MTFs, portions of Human Systems Wing (HSW), etc.) are placed in either a standard deployable UTC or an associate UTC and given an AEF assignment in the Medical Readiness Decision Support System (MRDSS). Personnel assigned to institutional force (IF) designated UICs (e.g. HAF, MAJCOM, training units) will have an AEF Indicator (AEFI) of X, and will not be postured in UTCs.

1.2.3.1. UTC assigned medical forces are presented as Health Service Support (HSS) Demand Force Teams (DFTs) to meet CCDR requirements and/or AF missions. AC capabilities are managed at 1:2 deploy-to-dwell ratio and ARC capabilities are managed at a 1:5 mob-to-dwell ratio. Medical DFTs are presented in five categories to provide the full range of HSS to deployed and in-place warfighters and enable global patient movement with CCATTs and patient staging capabilities.

1.2.3.1.1. Home Station Health Service Support Teams. Provide and enhance a healthy and fit force from accession to veteran includes optimizing health/fitness of peacetime forces, maintaining health/fitness of deployed forces, and restoring the physical and mental health of redeployed service members.

- 1.2.3.1.2. Expeditionary Medical Support Teams. Provide rapidly deployable medical capability for up to five separate operating locations of varying sizes in support of an AETF or other contingency operations.
- 1.2.3.1.3. Expeditionary En-route Care Teams. Provide CCATT's and 700 combined staging beds at up to six operating locations in support of the global patient movement mission.
- 1.2.3.1.4. Special Operations Medical Support Teams. Provide small, highly skilled, tactically trained medical teams that utilize lean and tailored equipment packages in support of US Special Operations Command (USSOCOM) missions.
- 1.2.3.2. All UTC assigned personnel will be aligned to a specified HSS DFT and postured in AEF vulnerability periods in accordance with the approved AFMS Prioritization and Sequencing Guidance and the AFMS Medical Resource Letter (MRL).
- 1.2.4. Constant Deployer Model (CDM). The AFMS supports the Air and Space Expeditionary Force (AEF) strategy and postures its deployable capabilities evenly across the AEF. These deployable forces are mainly assigned to large medical treatment facilities using a CDM. The model maximizes laydown of key teams at facilities most able to provide the complex clinical caseload required for clinical currency while simultaneously providing sufficient copies of a UTC to support each AEF vulnerability period. By concentrating deployment capability at large facilities, individuals and teams are able to leverage their home-station responsibilities to maintain readiness currency in individual tasks, and to a large degree, team METs. Additional guidance and information may be found in AFI 10-401, *Air Force Operations Planning and Execution*, AEF On-line page, and the AFMS Posturing and Sequencing Guide.
- 1.2.5. Consultant Balanced Deployments (CBD). The CBD concept ensures AEF deployment requirements are met using the most qualified individuals available at any one time from across the AFMS by balancing deployments for their specialty, primarily those considered critical operational readiness Air Force Specialty Codes (AFSC). Additionally, this concept limits interruptions to home station health care and maximizes individual career development and growth. Refer to the AFMS Posturing and Sequencing (P&S) Guidance for additional information.
- 1.2.6. Stability Operations. The term "stability operations" refers to various military missions, tasks, and activities conducted outside the United States in coordination with other instruments of national power to maintain or reestablish a safe and secure environment, and provide essential government services, emergency infrastructure reconstruction, and humanitarian relief. The Air Force must be prepared to work with other Services to conduct stability operations throughout all phases of conflict in both combat and non-combat environments. Stability operations may be small or large scale, lasting for the short or long-term.
- 1.2.6.1. Integrated military and civilian operations are essential to successful stability operations; consequently, the Air Force will collaborate with other Services and US governmental agencies, foreign governments, international government and nongovernmental organizations, and private sector firms as directed to plan, prepare for

and conduct stability operations. The AFMS has a critical role in supporting stability operations by providing essential medical services and providing humanitarian assistance.

1.2.6.2. AF medical personnel and capabilities must be prepared to meet military and civilian health requirements in medical stability operations. To meet this requirement, training will be provided to prepare personnel for stability operations in accordance with DODI 3000.05, *Stability Operations*, and DODI 6000.16, *Military Health Support for Stability Operations*.

1.2.7. Joint Interoperability. The AF fights jointly. In recent years, OSD has reinforced commitment to joint interoperability and joint training in most strategic planning and training documents. This commitment is seen in using METs for training and expanding training opportunities through the use of joint field exercises as training venues for AFMS teams, when appropriate. Teams that are likely to deploy with medical teams from a different Service, or in direct support of a joint operation such as casualty staging and CCATTs, are prime candidates for a joint exercise operation.

**1.3. Medical Emergency Management.** AF fixed medical facilities worldwide plan for conducting their home station and expeditionary missions simultaneously. Home station missions include facility expansion, which can increase the bed capacity of some MTFs to receive and care for large numbers of casualties; medical surveillance; Chemical, Biological, Radiological, Nuclear (CBRN) detection and analysis; patient decontamination; and medical response/support to contingencies confined to the installation or involving Federal, State, Local, or Tribal agencies, or Host Nation governments, including CBRN incidents. The AFMS also participates in the National Disaster Medical System (NDMS) with Federal Coordinating Centers (FCCs) capable of receiving, triaging, and distributing civilian patients to NDMS hospitals and with Primary Receiving Centers and Secondary Centers capable of receiving, treating and holding military patients resulting from a military or homeland contingency. Designated AF MTFs serve as FCCs and Secondary Coordinating Centers (SCCs) within the NDMS, providing support and leadership to the local hospitals contributing to the NDMS bed capability. Air National Guard medical personnel may be tasked to serve at the Joint Force Headquarters (JFHQ) Joint Operations Center as planners and liaison officers to provide state level Defense Support to Civil Authorities (DSCA). To maintain a capability to respond to all contingencies, the AFMS relies on highly-trained medical warriors and state-of-the-art, light, ruggedized medical equipment. Comprehensive planning and realistic exercises ensure personnel are prepared to support expeditionary and humanitarian assistance and disaster relief (HA/DR) operations. Overarching guidance for the AF emergency management program and the AF Incident Management System (AFIMS) is contained in AFI 10-2501, *Air Force Emergency Management (EM) Program Planning and Operations*. Specific details on the AFMS emergency management mission are provided throughout this Instruction. Additional information on NDMS can be found on the AF Medical Readiness SharePoint Site at: <https://cs3.eis.af.mil/sites/OO-SG-AF-83/default.aspx>, in the NDMS folder.

**1.4. Medical Readiness Training.** AFMS personnel require highly specialized initial, sustainment, and theater-specific training to respond to varied missions and environments. To meet an all-hazards incident response capabilities also requires the training outlined in AFI 10-2501. A continual assessment process ensures this training remains relevant and effective.



1.4.1. Current Training System. Training is provided for individuals, teams (collective training), and leaders, that prepares personnel to integrate themselves into joint medical platforms and situations. The training system includes AFSC-awarding training courses, clinical currency platforms, courses for deployment platforms, local courses and briefings, and exercises.

1.4.2. Fully Qualified Mindset. Personnel should not be assigned to a readiness tasking or standard UTC until they hold a fully qualified AFSC (4XX3 for officers or 4XX51 enlisted). However, personnel holding AFSCs 4XX1 for officers and 4XX31 for enlisted may be substituted on UTCs in accordance with AFI 10-403, *Deployment Planning and Execution*, as long as sufficient oversight and skill capability is present on the UTCs. The unit commander must review UTC assignments to ensure mission capability. (T-2)

**1.5. Manpower and Equipment Force Packaging (MEFPAK) Responsible Agencies (MRA).** To maintain the viability and effectiveness of its deployable medical capabilities, the AFMS has assigned MEFPAK responsibilities to MAJCOM/SGXs. Air Combat Command is the MRA for medical ground-based unit type codes (UTCs) and the lead MAJCOM for the Medical Counter-Chemical, Biological, Radiological, Nuclear (MC-CBRN) program. Air Mobility Command is the MRA for AE, patient staging, aeromedical en route care support personnel and equipment UTCs, and patient movement items (PMI). Air Force Special Operations Command is the MRA for special operations medical UTCs. Additional MAJCOMs with mission or theater-unique capabilities requirements may also serve as a MRA with AF/SG3X approval. Pilot units work closely with the MRAs to construct UTCs, associated mission capability statements (MISCAPs), and manpower details.

**1.6. Medical Readiness Resourcing.** To maintain a robust medical readiness capability, the AFMS manages the funding for training, exercises, personnel and equipment through an internal planning, programming, and budgeting system.

**1.6.1. Readiness Requirements Planning and Resourcing (RRPR).** The goal of the RRPR is to program for and execute Line of the Air Force Working Capital Fund Medical Dental Division, Line of the Air Force O&M, and Defense Health Program (DHP) Medical Resources. The primary objectives of the RRPR process are to: (1) create a knowledgeable, cross-functional decision process that enables and tracks the execution of AFMS readiness programs; (2) capture the AFMS specific capability requirements needed by CCDRs to support joint war fighting medical support, (3) focus resource needs for organize, train and equip functions; (4) provide a validation mechanism to review requirements and apply resources; (5) communicate AF/SG intent regarding application of resources; and (6) provide best possible recommendations to the AF/SG regarding readiness programs.

1.6.1.1. Medical Readiness Panel (MRP). The MRP is the AFMS center of expertise for all readiness-specific organize, train, equip and plan functions and serves as the first level of corporate review. The panel is the initial point of entry for issues from PEMs and MRAs that require corporate review. The panel reviews and develops options for presentation to the corporate board. Throughout the year, the MRP focuses upon information collection and meets as required. The MRP is chaired by AF/SG3X.

1.6.1.2. The MRP ensures resources are provided across the AFMS to create and maintain global response initiatives. Medical readiness resources are provided by

Defense Health Programs (DHP) funding for operations and maintenance (O&M) and PMI, and LAF funding for War Reserve Materiel (WRM) and MC-CBRN assets.

1.6.2. Business Planning. Medical treatment facility commanders execute a business plan that maximizes the use of assigned personnel and available resources. This strategy allows a commander to plan and execute effective training at a predictable cost in terms of both resources and medical treatment facility production in three ways: readiness case analysis, currency case analysis, and business case analysis. Readiness is a critical element of business planning and should include training requirements, exercise opportunities, and deployment and contingency response obligations.

1.6.3. Medical Counter-CBRN (MC-CBRN) Resources. The AFMS plans for contingencies that exceed the normal operating capacity of field units. The AFMS utilizes LAF MC-CBRN funds to provide additional material needed to execute the Medical Contingency Response Plan (MCRP) during these situations. This material is presented as the 886 allowance standards (AS) for AC and reserve units, and 976 AS for ANG (Attachment 3) to enable standardized training, as well as centralized logistics and maintenance support. This materiel will continue to be modernized and funded within the DoD Chemical Biological Defense Program (CBDP) and AF Operations & Maintenance (O&M) program element (PE) 28036F (MC-CBRN) (AC and non-located AFRC units) and ANG O&M PE 58036F (MC-CBRN), but will be fielded by the medical unit as all-hazards emergency management resources in support of the MTF's MCRP, or the ANG's support of their Installation's Emergency Management Plan (IEMP) 10-2, DSCA or local support agreements. LAF funding may only be used to replenish items as required for shelf life management and to replenish those consumed during contingencies, exercises, and training involving CBRN hazards. Replenishment of AS materiel consumed during contingencies, exercises, and training not involving CBRN hazards will be replenished using appropriate exercise funding or DHP if an MTF Health Services related mission requirement.

1.6.3.1. The 886 AS provides a capability starting point which can then be tailored to meet the unique needs of each MTF. For full-time non-located AFRC bases, this capability shall be maintained by the Bioenvironmental Engineering/Public Health Office. For ANG Medical Units, this capability will be assigned under the 976 MC-CBRN program to the full-time medical staff.

1.6.3.2. MC-CBRN resources (also referred to as Home Station Medical Response, HSMR, in unrevised documents) are programmed at the AF/SG and NGB/SG levels by consolidating input from MAJCOMs and DRUs, and advocating for MC-CBRN requirements through the AF and ANG Installation Support Panels.

1.6.3.3. The NG HRFs/CERFPs provide unique military and civilian life saving capabilities and expertise to assist the Governors in responding to a CBRNE or other mass casualty incident which may include large numbers of fatalities. These NG HRFs/CERFPs can be available 24 hours a day, 7 days a week for regional or national deployment for response operations. Guidance for the HRF/CERFP mission can be found in NGR 500-4/ANGI 10-2504, *National Guard CBRNE Enhanced Response Force Package Management*, and NGB HRF/CERFP Yearly Guidance. These documents prescribe policies, procedures, training, and responsibilities governing the deployment

and employment of HRF/CERFP in support of the National Guard Homeland Security mission.

1.6.4. Unit Medical Operations Resourcing. The unit Medical Readiness Committee (MRC), or Executive Management Committee (EMC) for ARC units, identifies unit readiness training and resource requirements and provides a consolidated document to their respective MAJCOM. For a full discussion of medical resource processes and procedures see AFI 41-120, *Medical Resource Operations*.

**1.7. Aeromedical Evacuation (AE).** "The AFMS partners with the Operations (A3) community to provide AE capability for homestation and global operations. The A3 staff provides comprehensive operational AE readiness guidance in AFI 10-2912, *Aeromedical Evacuation Readiness Programs*, while the SG staff is responsible for clinical guidance for AE crews and medical/training guidance for SG managed AE UTCs, including WRM medical equipment allowance standards and operational CCATT/AE kit support program. Training, plans, and reporting requirements listed in this instruction for fixed medical facilities (medical units) do not apply to AE units.

**1.8. Global Medical Operations Plans and Reporting.** Realistic, comprehensive plans that describe responsibilities and procedures to perform the unit's mission are critical in building and maintaining highly effective medical response. Reporting systems, such as Status of Resources and Training System (SORTS), Defense Readiness Reporting System (DRRS) Enhanced Status of Resources and Training System (ESORTS), AEF Reporting Tool (ART), and other reports, provide planners at Combatant Commands, MAJCOMs, and senior leaders valuable data with which to make planning and resourcing decisions relevant to myriad AF taskings. Unit planning for global medical operations is discussed in Chapter 5, and medical readiness reports are discussed in Chapter 9 of this Instruction.

**1.9. Special Command Considerations.** Policy guidance for commanders of Limited Scope (LS), Limited Scope with Inter-service Support (LSISS), and deployed MTFs may differ from that provided for other MTFs. Specific provisions for these units are provided in Chapters 4, 5, 6, 7 and 8 of this Instruction.

1.9.1. LS MTFs are medical functional flights and small medical squadrons that do not provide the scope of services found in a Medical Group (includes Reserve Medical Units (RMU)). LS MTFs are assigned to non-medical squadrons or groups (e.g. Air Base Squadrons, Mission Support Groups or Air Base Groups). In some cases, the LS MTFs may report directly to the wing. **Note:** ARC units are considered LS MTFs for all requirements in this AFI.

1.9.2. LSISS MTFs are tenant units on bases where at least two Services share resources. Joint base MTFs that are host units are not considered LSISS MTFs.

1.9.3. Deployed MTFs. Any AF medical facility established in response to a contingency situation may be termed a deployed MTF by HQ AF/SG.

## Chapter 2

### ROLES AND RESPONSIBILITIES

**2.1. Purpose.** This chapter describes roles and responsibilities for Air Force Medical Readiness (MR) programs, including those at the Air Force, MAJCOM, installation and unit levels. It also describes responsibilities of supported and supporting organizations such as the Air Force Inspection Agency, Air Force Expeditionary Medical Skills Institute, and others.

2.1.1. Air Force Surgeon General (AF/SG). This individual will:

2.1.1.1. Develop medical policy for SECAF approval and issue guidance and procedures to implement the policy.

2.1.1.2. Advocate for, obtain, and allocate resources for medical activities.

2.1.1.3. Continually evaluate AFMS ability to support AF and DOD missions.

2.1.1.4. Integrate AFMS capabilities with other Air Force and Joint capabilities at the development and execution stages.

2.1.1.5. Establish and disseminate training and assessment guidance.

2.1.1.6. Establish the MR Panel by charter to plan, program, and budget for readiness resources.

2.1.2. Assistant Surgeon General, Medical Force Development (AF/SG1). This individual will:

2.1.2.1. Establish medical force development guidance.

2.1.2.2. Provide policy and guidance related to the recruitment and retention of AFMS personnel required for all medical missions.

2.1.2.3. Develop and implement career paths within medical readiness to ensure leadership and professional development.

2.1.2.4. Ensure medical personnel have initial and recurrent training programs/platforms to meet identified initial and recurrent operational training requirements.

2.1.2.5. Ensure AFSCs appropriately represent the capabilities defined by MISCAPs and take appropriate management/development actions as needed.

2.1.2.6. Serve as consultant/advisor to AFMS MTFs, AFRC/SG and NGB/SG on the development of memorandums of understanding (MOUs) and local training affiliation agreements for standardized training opportunities for medical-surgical services, medical support, or force enhancement personnel at civilian, Veterans Administration (VA) or Joint facilities.

2.1.3. Assistant Surgeon General, Health Care Operations (AF/SG3). This individual will:

2.1.3.1. Develop medical readiness doctrine, guidance, and programming. Publish and maintain associated directives.

2.1.3.2. Advocate for, obtain, and allocate resources for medical readiness activities, including training.

- 2.1.3.3. Recommend medical readiness strategies to the AF/SG.
- 2.1.3.4. Ensure Medical Readiness Decision Support System Unit Level Tracking and Reporting Application (MRDSS ULTRA) is maintained and funded, and continues to be enhanced as AFMS mission requirements evolve.
- 2.1.3.5. Develop a functional AEF medical UTC deployment strategy.
- 2.1.3.6. Publish the Medical Resource Letter (MRL), identifying AFMS UTC and MC-CBRN assemblage apportionment.
- 2.1.3.7. Designate the Director, Medical Readiness (AF/SG3X) to:
  - 2.1.3.7.1. Maintain the MRL and the medical UTC Availability (UTA), ensuring expeditionary medical capabilities are balanced across the entire AEF.
  - 2.1.3.7.2. Coordinate with MAJCOM medical functional area managers (FAMs) to ensure maximum support of the AFMS UTC posturing strategy.
  - 2.1.3.7.3. Provide functional oversight and guidance to MAJCOM/SGXs on all aspects of medical readiness, to include policies, procedures, and publications; deployment and operational information and taskings; training development and opportunities; installation medical response guidance; and resource allocation.
  - 2.1.3.7.4. Develop courses of action to balance AEF rotational requirements and beneficiary healthcare requirements.
  - 2.1.3.7.5. Provide functional guidance and oversight of the Consultant Balanced Deployment program.
  - 2.1.3.7.6. Publish and maintain this Instruction and associated self-assessment checklists (SAC) within the Management Internal Control Toolset (MICT), in accordance with AFI 33-360, and AFI 90-201, *The Air Force Inspection System*. Publish and maintain the AFI 41-106 Toolbox on the AF Medical Readiness SharePoint Site.
    - 2.1.3.7.6.1. Collect, track and evaluate change requests and publish changes to this Instruction as mission dictates.
    - 2.1.3.7.6.2. Update, coordinate and maintain the Medical Readiness Self-Assessment Checklist within Management Internal Control Toolset (MICT), in support of the Wing Commander's Inspection Program (CCIP).
  - 2.1.3.7.7. Through the respective MAJCOMs, designate specific MTFs to operate as Laboratory Response Network (LRN) laboratories.
  - 2.1.3.7.8. Chair the Medical Readiness Panel (MRP). Provide oversight of the RRPR Process including: (1) Management of the program objective memorandum (POM) requirements change process; (2) Managing POM requirements in the POM Grid application across the Fiscal Years to reflect approved changes; and (3) Reconciliation of POM requirements to the MRL and identification of disconnects to the MRAs for correction of the MRL.
  - 2.1.3.7.9. Establish the MRDSS Configuration Control Board (CCB) by charter. The MRDSS CCB validates and prioritizes proposed baseline software changes.

2.1.3.7.10. Establish the Readiness Training Oversight Committee (RTOC) by charter to review AFMS medical readiness training programs to ensure such programs are adequately designed to fulfill defined medical readiness training requirements. The RTOC will also plan, coordinate and oversee the AFMS exercise program. Units with unique or extensive exercise requirements beyond the scope of unit funding may submit their proposals through their MAJCOM/SGXs to the RTOC for consideration. Consultants, corps directors or AF Career Field Managers (CFM) may also submit funding proposals to the RTOC for Readiness Skills Verification Program (RSVP) training requirements not funded by other programs.

2.1.3.7.11. Appoint a member of the AF/SG3X staff as the Program Element Manager (PEM) for the following DHP, Program Elements (PE): 87700 - Defense Medical Centers, Station Hospitals and Medical Centers – CONUS; 87714 - Other Health Activities; 87724 - Military Unique Requirements - Other Medical - Health Care; 87725 - Aeromedical Evacuation System - Health Care; 865XX – PMI; 87900 - Defense Medical Centers, Station Hospitals and Medical Centers – OCONUS. The MR PEM is the primary advocate for medical readiness funding and supports the RTOC, MRDSS CCB, and the International Health Specialist (IHS) program.

2.1.3.7.12. Appoint a member of the AFMSA/SG3X staff as the PEM for LAF PE 28036F, MC-CBRN program. The MC-CBRN PEM is the primary advocate to the Installation Support Panel on behalf of the AFMS for MC-CBRN program funding throughout all aspects of the AF Planning, Programming, Budgeting, and Execution System (PPBES) process. The PEM will:

2.1.3.7.12.1. Provide MC-CBRN programming requirements to the Medical Readiness Panel for approval, as recommended by HQ ACC/SGXH.

2.1.3.7.12.2. Advocate for sustainment requirements through the AF Installation Support Panel for garrisoned airbases and through the Rapid Global Mobility Panel for UTCs.

2.1.3.7.12.3. Upon initial distribution, facilitate flow of MC-CBRN funds programmed for sustainment of MTF assemblages and training to MAJCOM comptrollers for further distribution to ABW comptrollers. The AFMSA PE 28036F PEM will forward funding to program execution offices to process funding documents for central bills such as maintenance contracts and central procurement items according to ACC/SGX execution year priorities. The NGB PE 58036F PEM will process funding documents for central bills such as maintenance contracts and central procurement items according to NGB/SG execution year priorities.

2.1.3.7.13. Appoint a PEM for the AFMS War Reserve Materiel (WRM) PE 28038f that provides Air Force Working Capital Funds (Fund Code 4930) for UTC materiel requirements and LAF Operating and Maintenance funding (Fund Code 30) for maintenance and sustainment support services. The PEM will:

2.1.3.7.13.1. Serve as the primary advocate addressing issues and coordinating functional concerns across various staffs.

2.1.3.7.13.2. Facilitate an annual portfolio management workgroup (MRA's)

meeting each December to produce the AFMS WRM Prioritized POM Position (PPP) with the outcome documented in the AF Medical Logistics Web enabled Spend/Production Plan database application.

2.1.3.7.14. As the Associate Corps Chief for Readiness, AF/SG3X will:

2.1.3.7.14.1. Work with AF/A5XW to establish and periodically review criteria for award of the “R” AFSC prefix for medical personnel, for inclusion in the AF Officer Classification Directory (AFOCD) and AF Enlisted Classification Directory (AFECD).

2.1.3.7.14.2. Develop a process to identify MAJCOM, Component Numbered Air Force (C-NAF), Joint, Air Staff, and other staff positions eligible for the “R” AFSC prefix.

2.1.3.7.14.3. Establish a process to periodically review both R-coded positions and R-coded personnel. Revocation of a person’s R prefixed AFSC will be coordinated with AF/A5XW in accordance with AFOCD guidance.

2.1.4. Air Force Medical Support Agency/Research and Acquisitions Directorate (AFMSA/SG5). This agency will:

2.1.4.1. Establish an MC-CBRN thrust area to create linkage between new concepts and strategies, MAJCOM/SG combat developers, the AFMS modernization portfolio, and the Joint Chemical Biological Defense Program.

2.1.4.2. Assign a liaison to the AF CBD Acquisitions Agency at Edgewood, MD to facilitate materiel development.

2.1.4.3. Submit approved MC-CBRN modernization requirements to AF/A7CX for input into the Joint Chemical/Biological Defense POM.

2.1.5. Assistant Surgeon General, Strategic Medical Plans and Programs (AF/SG8). This individual will:

2.1.5.1. Establish threshold manning levels required to support contingency requirements using planning tools including the Contingency Operational Readiness Requirement (CORR).

2.1.5.2. Program sufficient forces to meet changing operational requirements in the specialties needed.

2.1.6. Air Force Medical Operations Agency (AFMOA). This organization will:

2.1.6.1. Provide oversight to AFMS consultant and CFM functions.

2.1.6.2. Support the Readiness Skills Verification Program (RSVP) and Consultant Balanced Deployment (CBD) functions.

2.1.6.3. Provide funding, management direction and oversight in support of WRM Consolidated Storage and Deployment Center (CSDC) operations in accordance with established memoranda of agreement (MOA).

2.1.6.4. Provide medical logistics policy, procedures, management, and execution for medical contingency materiel programs in accordance with AFI 41-209, *Medical Logistics Support*.

2.1.6.5. Provide policy, guidance and requirements management for the AFMS WRM Force Health Protection Program, which includes the Biological and Chemical Warfare countermeasures and Anti-Malaria programs.

2.1.7. Air Force Medical Support Agency, Medical Readiness Directorate (AFMSA/SG3X). This organization will:

2.1.7.1. Support the development of medical readiness doctrine, guidance, and programming. Provide daily oversight and accountability for medical readiness processes.

2.1.7.2. Provide functional guidance and assistance to MAJCOM/SGXs on all aspects of medical readiness, to include decisions, procedures, and publications; deployment and operational information and taskings; training development and opportunities; installation medical response guidance; and resource allocation, to include equipment funding.

2.1.7.3. Provide recommendations to AFMOA/SGAL on procuring, storing, sustaining, reporting, and updating Medical Readiness program equipment and supplies.

2.1.7.4. Provide policy guidance and oversight of the Readiness Skills Verification Program (RSVP).

2.1.7.5. Collaborate with HAF, joint, and ASD (HA) offices to analyze strategic guidance in support of concepts and strategies to counter CBRN threats.

2.1.8. Medical Inspection Directorate, Air Force Inspection Agency (AFIA/SG). This agency will support deployed MTF assessments using the Deployed MTF Assessment Tool provided on the AF Medical Readiness SharePoint Site.

2.1.9. Air Force Personnel Center Medical Directorate (HQ AFPC).

2.1.9.1. The Directorate of Personnel (DPAM) will:

2.1.9.1.1. Maintain published guidance outlining the process for submitting applications for Category I continuing medical education (CME) and other continuing education credit for medical readiness training courses.

2.1.9.1.2. Review and approve applications for Category I CME and continuing education credit when content meets the appropriate criteria.

2.1.9.2. The Directorate of AEF Operations (DPW) Functional Area Scheduler will:

2.1.9.2.1. Identify/recommend any changes to the UTC alignment.

2.1.9.2.2. Source UTCs using available tools, including MRDSS ULTRA, following applicable sourcing rule sets to meet all CCCR crisis, rotational, and individual augmentation requirements as stated in time-phased force deployment data (TPFDD).

2.1.9.2.3. After consulting with the AFMS Functional Area Manager (FAM) use the MAJCOM coordinated and AF/SG approved Enabler battle rhythm to source CCCR crisis response requirements, and/or AF/SG3X approved rotational taskings.



2.1.9.2.4. Track residual capability and notify HQ ACC/SGX, AFMS FAM, AF/SG3XO (Medical Operations Center), and MAJCOM FAMS when surge operations are required.

2.1.10. Consultants, Corps Directors and Air Force Career Field Managers (CFM). These individuals will:

2.1.10.1. Monitor, support, and provide functional guidance for the Readiness Skills Verification Program (RSVP). Determine critical knowledge and performance skills required of all deploying medical personnel and standardize baseline AFSC skills across the AFMS. Develop, maintain, refine and validate RSVP checklist tasks and training sources, utilizing the RSVP flowchart provided on the AF Medical Readiness SharePoint Site. RSVP tasks or skills should be deployment related tasks and not tasks or skills individuals perform on a daily basis at home station. In addition, do not include tasks or skills already covered in formal UTC courses or as part of enlisted upgrade training unless UTC course or upgrade training frequency is not adequate to ensure or maintain proficiency. Determine RSVP task training frequency, considering the AEF deployment cycle, training platform constraints, and the duration of required skills or certifications.

2.1.10.1.1. Review RSVP checklists annually for currency and provide changes or status update to Air Force Expeditionary Medical Skills Institute (AFEMSI), on the anniversary date of the existing checklist.

2.1.10.1.2. Notify AFEMSI when RSVP knowledge and performance checklists have been updated and provide implementation guidance in memo form, for dissemination to the field. The implementation memo should include, at a minimum: suggested methods for accomplishing new tasks that may exceed capabilities at some MTFs; alternate sources of training credit, such as formal course attendance or other training venues; and an implementation timeline. A link to the training reference or source for each RSVP task or skill will be provided to the AFEMSI program manager and be reviewed during annual review. Personnel will normally be given six months to complete new RSVP task training unless the new tasks address a known training or capability shortfall. In such cases the consultant, corps director or CFM will provide specific guidance.

2.1.10.1.3. Analyze gap analyses submitted by AFSC functional training managers. The gap analysis results will be divided into two types of training: local and non-local. Local training is defined as that which can be accomplished at the unit level through training affiliations or special training events. Non-local training may require AFMOA-level consultant or CFM assistance. Local items must be accomplished within established RSVP task timelines. Non-local items must be completed within 48 months of unit submission of the gap analysis to the consultant or CFM.

2.1.10.1.4. Maintain a list of current training sources and identify cost-effective methods for accomplishing RSVP non-local training gap items (e.g. computer-based training, web-based resources, formal courses, etc.) to unit AFSC Functional Training Managers.

2.1.10.1.5. Work with AFEMSI to reconcile RSVP tasks and mitigate training shortfalls.

2.1.10.1.6. Reference Chapter 5 of this Instruction for additional RSVP guidance.

2.1.10.1.7. Review post-deployment RSVP feedback provided by AFEMSI. Identify potential training deficiency trends and determine if changes to existing RSVP checklists are warranted. If RSVP checklist changes are required provide an ECD to AFEMSI.

2.1.10.1.8. Manage requests for RSVP training waivers or exemptions on a case-by-case basis.

2.1.10.1.9. Work with the AEF Operations Center and the AFMS FAM to generate and maintain a list of available critical operational readiness deployers in MRDSS ULTRA. The lists will be coordinated electronically, within MRDSS ULTRA, with the affected MAJCOM/SGXs and units. In addition, consult with HQ ACC/SGX, the AFMS lead for developing ground base medical force and capability sourcing solutions.

2.1.10.2. Identify training requirements for prioritized FFZZZ personnel and notify the parent MAJCOM/SGX. Facilitate training slot assignments as necessary. Identify special training requirements, such as Centers for Sustainment of Trauma and Readiness Skills (C-STARS), for individuals tasked or identified to deploy based on tasking authority requirements for anticipated deployment location or operational role (see Chapter 5 for specific C-STARS guidance).

2.1.10.3. Review personnel UTC assignments and recommend to MAJCOM/SGXs and unit commanders realignment of personnel within the AEF construct for critical operational specialties where required, maximizing use of personnel from the same facility to fill UTCs. Recommend individuals from other MAJCOMs to complete the UTC or fill a unit line number (ULN) requirement for an AEF rotation at execution only when necessary.

2.1.10.4. Throughout the process, mitigate risk to overall deployment and home station missions through effective management of available deployers.

2.1.11. Component Numbered Air Force (C-NAF) Surgeons. These individuals will:

2.1.11.1. Provide medical expertise and input to deliberate and crisis planning operations.

2.1.11.1.1. Determine operational and rotational UTC deployment requirements and enter them into the TPFDD.

2.1.11.1.2. Coordinate changes in operational requirements with AF/SG3X to facilitate sourcing.

2.1.11.1.3. Periodically review and validate plan requirements as part of the RRPR process.

2.1.11.2. Execute medical readiness missions in support of C-NAF and Combatant Command theater plans.

2.1.11.2.1. Comply with Joint and Air Force deployment guidance and deconflict operational guidance as needed.

- 2.1.11.2.2. Provide International Health Services (IHS) capability (AD or ARC) in support of theater health engagement activities in accordance with AFI 44-162, *International Health Specialist (IHS) Program*.
- 2.1.11.3. Assess the effectiveness of deployed medical operations using the Deployed MTF Assessment Tool provided on the AF Medical Readiness SharePoint Site.
- 2.1.11.3.1. Conduct periodic assessments of deployed MTFs. MTFs in enduring operations for more than two years with permanent (365 days) and other facilities as deemed appropriate by the C-NAF/SG will be assessed. Scheduling is subject to CCDR approval and Area of Responsibility (AOR) activity.
- 2.1.11.3.2. C-NAF/SG staffs will conduct the assessments, relying upon subject matter expertise from outside agencies, including AFIA, AFMOA, HAF, MAJCOM, and/or MRA, as required, to fill specifically identified functional knowledge gaps.
- 2.1.11.4. Evaluate Building Partnerships, Building Partnership Capacity, and Stability Operations against developed measures of effectiveness. Measures of effectiveness must be linked to a specified end state objective and be specific, measurable, attainable, realistic, and timely.
- 2.1.11.5. Ensure lessons learned are identified via Joint Lessons Learned Information System (JLLIS) to inform higher headquarters of capability gaps and deficiencies that may require changes to existing organize, train, and equip policies and functions.
- 2.1.11.6. Provide guidance for reporting unit operational status, availability, and patient care capabilities during contingency operations.
- 2.1.12. Manpower and Equipment Force Packaging (MEFPAK) Responsible Agencies. MEFPAK Responsible Agencies (MRAs) will comply with all MEFPAK requirements identified in AFI 10-401 and AFI 41-209, *Medical Logistics Support*. In addition, the MRAs will:
- 2.1.12.1. Develop and maintain UTCs to meet operational requirements. Appoint pilot units for each UTC. Pilot units may be medical organizations outside the MRA with coordination of the gaining MAJCOM/SG. Develop UTC METs based on force module packaging or for stand-alone UTCs, and will incorporate them into the appropriate MRA Playbook.
- 2.1.12.2. Prepare a playbook for each UTC, consolidating incremental UTCs into a single playbook for each medical force package, as appropriate. The playbook will serve as a consolidated resource for all information regarding the UTC, to include: personnel and equipment detail; mission capability; concept of operations (CONOPS); tactics, techniques, and procedures (TTP); individual UTC weapons and arming requirements; mission essential task lists (METL); and UTC modernization and funding information.
- 2.1.12.3. Prepare an annual status report on assigned UTCs. This report, prepared in a manner prescribed by the AF/SG should include current status of on-hand systems and personnel, modernization efforts and concerns, and is forwarded on a schedule established by the AF/SG.
- 2.1.12.4. Manage WRM UTCs and support requirements, to include support of WRM Consolidated Storage and Deployment Center (CSDC) operations; verification of CCDR

deployment taskings; recommendations and input to WRM spend plan process; and training/exercise requirements. Participate and support WRM CSDC operations in accordance with established MOUs.

2.1.12.4.1. Verify CCDR requirements and task assets for deployment as necessary in coordination with the CSDC WRM managers and associated wing installation deployment officers.

2.1.12.4.2. Coordinate requests to store and manage additional UTCs at CSDC locations with AFMOA/SGALX.

2.1.12.4.3. Maintain control, oversight, configuration management, and tasking authority for WRM managed and maintained at the CSDCs.

2.1.12.4.4. Coordinate with AFMSA/SG3X and AFMOA/SGALX all requests to deploy a WRM UTC for training or exercise.

2.1.12.4.5. Provide recommendations and input to the WRM spend plan process to ensure appropriate funding to support sustainment, reconstitution, and production requirements of consolidated WRM.

2.1.12.5. Develop training requirements for each UTC or force package, and identify funding requirements for training and exercises to the RTOC and AFMSA/SG3X as appropriate.

2.1.12.6. Plan and coordinate operational tests as necessary for the possible fielding of UTC, force packages, or installation response equipment with the pilot unit, other MAJCOM/SGXs, AFMSA/SG3X, AFMSA/SG9, or operational test agencies, as appropriate. Identify procurement and sustainment lifecycle costs in coordination with AF/SG3X and AFMSA/SG3X.

2.1.12.7. Coordinate with appropriate joint training agencies, Air Force agencies, and MAJCOM/SG to ensure that AFMS participates in major training exercises, including Joint Chiefs of Staff (JCS) exercises, in accordance with AFMS guidance.

2.1.12.8. Provide oversight and guidance to pilot units.

2.1.12.8.1. Identify pilot unit responsibilities in writing, outlining processes associated with program modernization or enhancements.

2.1.12.8.2. Ensure pilot units review UTC weapons requirements biennially. Update the Weapons and Munitions Forecasting Table for AFMS UTCs on the AF Medical Readiness SharePoint Site as necessary.

2.1.12.9. Fully coordinate all UTC development, changes, and cancellations with all using commands.

2.1.12.10. Ensure medical readiness requirements are represented in Combat Air Forces/Mobility Air Forces/Special Operations Forces (CAF/MAF/SOF) and AFMS strategic planning; AFMS sponsored medical modernization Research and Development efforts; AFMS and Line Program Objective Memorandum development/deliberations; integrated product teams and High Performance Teams capability gaps and requirement identification.

- 2.1.12.10.1. Annually meet with each component to collect the required information necessary to establish their Total Demand List (TDL). The TDL will include ALL requirements cited in all CCDR plans. At least once every two years MRAs will conduct a face-to-face meeting with each component and conduct a detailed assessment of CCDR plans to ensure all requirements are accurately described and accounted for on the TDL. Any theater operational requirement not currently a part of the AFMS deployable capability should be included as well.
- 2.1.12.10.2. Apply the AF/SGs strategic planning guidance, derived from Joint Strategic Capabilities Plan (JSCP), War and Mobilization Plan (WMP), and Defense Planning guidance (DPG), to the TDL to arrive at the Readiness Requirements List (RRL). MRAs will present their recommended RRLs annually at the secure MRP held in October (beginning in 2014). The RRL will be vetted and approved by the MRP and coordinated through the AFMS corporate process. The final RRL will be presented to the AF/SG for approval and will become the presentation of forces/capability for the CCDRs and guide resource programming.
- 2.1.12.10.3. Once approved and prior to the annual WRM portfolio management workgroup meeting MRAs will ensure the AF Medical Logistics Web enabled Spend/Production database POM Grid application accurately reflects the most current RRL.
- 2.1.12.11. MC-CBRN Lead MAJCOM and Consolidated MAJCOM Execution. The AF/CV designated ACC as the lead MAJCOM for C-CBRN capabilities. Inherent in ACC's designation is ACC/SG's role as lead for MC-CBRN capabilities. This complements ACC/SG's role as the MEFPK Responsible Agency (MRA) for ground medical UTCs that include expeditionary ground MC-CBRN capabilities. This combined lead MAJCOM and MRA role creates synergy in MC-CBRN capability development and sustainment in support of the AFMS commitment to interchangeable MC-CBRN kits and AF Tactics, Techniques, and Procedures (AFTTP). The HSMR transition to "sustained capability" and the shifts in MTF policy and process allows consolidated program execution, sustainment process management, and consultative support by a single MAJCOM/SG. ACC/SG will serve as this consolidated staff to leverage the staffs' MRA and MC-CBRN Lead MAJCOM expertise. Specific responsibilities include:
- 2.1.12.11.1. Allowance standard development and maintenance
  - 2.1.12.11.2. AFTTP development and maintenance
  - 2.1.12.11.3. Mission essential tasks and operational standards development
  - 2.1.12.11.4. Training requirements, quota management, and product standardization
  - 2.1.12.11.5. PE 28036F spend plan development for central bills
  - 2.1.12.11.6. PE 28036F programming inputs
  - 2.1.12.11.7. Oversight of central maintenance/procurement contract requirements
  - 2.1.12.11.8. Consultative support to MAJCOMs
  - 2.1.12.11.9. Site support visits upon MAJCOM request
  - 2.1.12.11.10. Readiness data monitoring and trend analysis

2.1.12.12. As the MRA for PMI, AMC/SG will provide funding, management direction and oversight in support of PMI Centers, and PMI operational support and training platforms and will develop and maintain the PMI CONOPS.

2.1.13. Major Command Surgeons (MAJCOM/SG) and National Guard Surgeon (NGB/SG). These individuals will:

2.1.13.1. Ensure that medical units are properly organized, trained, and equipped to carry out all aspects of their expeditionary and HA/DR missions in accordance with AF War and Mobilization Plan, Vol. 1 (AF WMP 1) guidance, Operation Plan (OPLAN) requirements and other applicable directives. For ARC units, this is additionally a gaining MAJCOM responsibility in accordance with AFI 10-301, *Responsibilities of Air Reserve Component (ARC) Forces*.

2.1.13.2. In concert with AFMOA, ensure each subordinate medical unit's manning document (UMD) is postured to balance readiness, business case, and clinical currency requirements.

2.1.13.3. Provide supporting guidance to assist with the implementation of AF guidance on expeditionary and HA/DR operations, training, and assessment.

2.1.13.4. Appoint a Public Health Officer (PHO) as the functional expert for Biological Warfare (BW) Disease Surveillance and Epidemiological response.

2.1.13.5. Appoint a Medical Corps Officer with experience in preventive medicine and/or emergency response, such as the assigned Chief of Aerospace Medicine (SGP), as the MAJCOM Public Health Emergency Officer (PHEO) Consultant. Reference AFI 10-2604, *Disease Containment Planning*, for additional guidance. The PHEO Consultant will maintain a list of primary/alternate Public Health Emergency Officers (PHEOs) and MTF Emergency Managers (MEMs) at subordinate Air Force installations. Provide a copy of the list to the HAF PHEO and HAF MEM whenever updates are made.

2.1.13.6. Provide Public Health Emergency Management (PHEM) course attendance nominations to AFMSA/SG3XT, as requested.

2.1.13.7. Provide oversight to the MAJCOM/SGX office (or standing force headquarters equivalent) in the performance of the following tasks:

2.1.13.7.1. Assist medical readiness officers (MROs), medical readiness NCOs (MRNCOs), and civilian medical readiness managers (MRMs) in resolving issues with their units' readiness programs.

2.1.13.7.2. Ensure force health protection guidelines for each area of responsibility are available to subordinate units.

2.1.13.7.3. Review unit Medical Contingency Response Plans (MCRPs) (or equivalent plans) prior to publication to validate medical response capabilities and verify compliance with AF directives. Ensure each team annex in the MCRP includes specific MC-CBRN response procedures, whether using assigned MC-CBRN assemblages or available resources. Reviews must be completed within 60 days of submission by the unit or concurrence is implied.

- 2.1.13.7.4. Collect and evaluate readiness guidance change requests from units and other subordinate organizations. Submit consolidated requests to AFMSA/SG3X.
  - 2.1.13.7.5. Coordinate with MRA as necessary regarding input to UTC manning, equipment, and training requirements.
  - 2.1.13.7.6. Monitor MRDSS ULTRA data to identify personnel, training, and equipment/supply trends, shortfalls and gaps.
  - 2.1.13.7.7. Identify MAJCOM MR program resource requirements for inclusion in the MAJCOM/SG POM and Execution Year budget submission. Additionally, notify the AF/SG MR Panel of resource requirements.
    - 2.1.13.7.7.1. Coordinate with ACC/SGXH to advocate to AF/SG3X and the MAJCOM FM for resources associated with LAF funded MR programs.
    - 2.1.13.7.7.2. Coordinate with other functional experts on MR resource requirements, as necessary.
    - 2.1.13.7.7.3. Ensure MAJCOM PEM for LAF PE 28036F (PE 58036F for ANG), MC-CBRN Program resides in the MAJCOM/SGX office (or standing force headquarters equivalent).
    - 2.1.13.7.7.4. Coordinate with ACC/SGX for MC-CBRN sustainment funding priorities, training quotas and consultative support. Manage all-hazards response processes that require integration or coordination with the MAJCOM A-staff.
  - 2.1.13.7.8. Coordinate and submit consolidated exercise requirements to the RTOC. Designate MAJCOM representatives to the RTOC to provide input to training and exercise priorities and schedules, and ensure unit participation prior to AEF vulnerability periods.
  - 2.1.13.7.9. Provide program oversight for MC-CBRN at the MAJCOM level to include distribution of MC-CBRN funding and other resources to help installation close capability gaps.
  - 2.1.13.7.10. Review unit NDMS-FCC Operations Plans prior to publication to verify compliance with AF and DoD directives. Ensure the plan accurately outlines roles and responsibilities, team composition and training, sufficient supplies and resources, and local/county emergency management processes to coordinate patient distribution and accomplish other NDMS support tasks. Reviews must be completed within 60 days of submission by the unit or concurrence is implied.
  - 2.1.13.7.11. Collect unit RSVP gap analysis documentation and forward to the appropriate AF SG consultant, corps director or CFM.
- 2.1.13.8. Designate a MAJCOM/SGX representative to provide MRDSS ULTRA support to MRDSS ULTRA Unit System Administrators. The MAJCOM MRDSS ULTRA representative will create, review, and delete MRDSS ULTRA Unit System Administrator user accounts, as appropriate, and ensure positive control of sensitive information contained within MRDSS ULTRA. This individual will provide assistance and guidance to Unit System Administrators with data entry and contact the MRDSS Help Desk if technical assistance is required.

2.1.13.9. Support the CBD process by coordinating on consultant/CFM recommendations and list of available deployers. Forward lists and recommendations to medical unit commanders for review and negotiation with consultants before final approval. Provide feedback to AFMS consultants and DPW as appropriate.

2.1.13.10. Appoint a MAJCOM Functional Area Manager(s). This individual/office will:

2.1.13.10.1. Consistently ensure accuracy of Medical Readiness Decision Support System (MRDSS), the UTC Availability (UTA) database, AEF UTC Reporting Tool (ART), individual unit Status of Resources and Training System (SORTS) Designed Operational Capability (DOC) Statements, and Defense Readiness Reporting System (DRRS) Mission Essential Task Lists (METLs) utilizing the approved MRL.

2.1.13.10.2. Submit change requests to an approved MRL using the MRL admin function of MRDSS and ensure changes have been accepted prior to updating the UTA database.

2.1.13.10.3. Assist subordinate units in determining the appropriate level of home station services to provide during AEF deployments.

2.1.14. Air Force Materiel Command Surgeon (AFMC/SG). This individual will:

2.1.14.1. Establish an MC-CBRN Support Function to provide direct support to ACC/SG, as lead MAJCOM for MC-CBRN, and AFMSA/SG3X in the:

2.1.14.1.1. Development and sustainment of the MC-CBRN documents and training products.

2.1.14.1.2. Collection of lessons learned from operations and MAJCOM assessments to improve METs, operational standards, TTPs and curriculum.

2.1.14.1.3. Integration of MC-CBRN concepts of employment into accession and formal courses for individuals and teams, as appropriate.

2.1.14.1.4. Leveraging of 711th Human Performance Wing (HPW) ties to universities, industry, AF Research Lab (AFRL), and organic expertise to fully inform analysis by AFMSA/SG3X, ACC/SG and the MRAs.

2.1.14.1.5. Maintenance of research/analysis repositories for each AFMS MC-CBRN capability.

2.1.14.2. Manage the Centers for Sustainment of Trauma and Readiness Skills (C-STARS) Training Matrix, in collaboration with the MRAs, consultants and CFMs, identifying C-STARS attendance requirements.

2.1.14.3. Coordinate an annual C-STARS data call with the MRAs and consultants to identify quotas and attendance prioritization.

2.1.15. United States Air Force School of Aerospace Medicine (USAFSAM), 711<sup>th</sup> Human Performance Wing, AF Research Laboratory, AFMC. This organization will:

2.1.15.1. Administer the C-STARS operating locations to maximize efficiency and effectiveness.



- 2.1.15.1.1. Collaborate with similar Joint sustainment programs for benchmarking purposes.
- 2.1.15.1.2. Develop new C-STARS locations as required by AF/SG3 to meet first responder, trauma care, critical care, and aeromedical evacuation personnel training requirements.
- 2.1.15.1.3. Oversee standardized program curricula for all C-STARS locations. Monitor these programs for quality and effectiveness, and work with the AF/SG Consultants and CFMs to update the curricula as needed. Collect student progress data every six months, at a minimum.
- 2.1.15.1.4. Brief the RTOC annually on C-STARS quota utilization, issues, and trends.
- 2.1.15.2. Provide consultative and staff assistance services to all trauma skills sustainment training sites.
  - 2.1.15.2.1. Collaborate with the Air Education and Training Command Surgeon (AETC/SG) to assist MTFs in establishing trauma skills sustainment training programs and support associated POM submissions as required.
  - 2.1.15.2.2. Monitor MTF execution of trauma skills sustainment training programs and establish associated inspection criteria. Compile and report data on all trauma skills sustainment training sites to AF/SG3X and MAJCOM/SGXs via the Readiness Training Oversight Committee (RTOC). Compile an annual training summary for AFMC/SG and AETC/SG.
- 2.1.15.3. Develop and conduct the CCATT Initial and CCATT Advanced UTC-specific courses, as requested by AMC/SG.
- 2.1.15.4. Manage the RSVP in collaboration with AF/SG1N, AFMSA/SG3X and AFMOA.
  - 2.1.15.4.1. Work with SG consultants, corps directors and CFMs to ensure RSVP checklists are reviewed annually and updated as necessary. Provide an RSVP checklist status update to AFMSA/SG3XT on a quarterly basis, at a minimum.
  - 2.1.15.4.2. Notify personnel 30 days in advance of RSVP checklist updates, using an MRDSS ULTRA system message and the messaging functions provided by the MRDSS Kx and AF Medical Readiness SharePoint sites to maximize distribution.
  - 2.1.15.4.3. Post RSVP task updates in MRDSS ULTRA and on the AFMS Kx site only after approval.
  - 2.1.15.4.4. Provide post-deployment feedback to the appropriate consultant, corps director or CFM for consideration for changes or updates to RSVP checklists.
- 2.1.15.5. Review/evaluate new advanced clinical sustainment programs as directed.
- 2.1.15.6. Promote medical research, particularly with expeditionary impact, across the military/civilian spectrum.
- 2.1.15.7. Provide technical expertise and consultative reach back capability in the areas of occupational and environmental health, public health and epidemiology, clinical and

environmental laboratory sciences, nuclear/radiological response, and occupational health physics support.

2.1.16. Air Education and Training Command Surgeon (AETC/SG). AETC/SG will:

2.1.16.1. Serve as a consultant/advisor to the AFMS on use of patient simulators and distance learning for development and sustainment of expeditionary clinical skills.

2.1.16.2. Support trauma skills sustainment training by:

2.1.16.2.1. Coordinating with AF/SG to obtain on-site simulators and qualified simulator staff to execute trauma skills sustainment training.

2.1.16.2.2. Providing oversight of contracted simulation personnel at trauma skills sustainment training sites.

2.1.16.2.3. Directing AETC/SGR to provide expertise and recommended equipment and supply lists needed to establish a simulation facility and develop simulation curriculum and scenarios in support of program objectives and requirements.

2.1.17. 937th Training Group (TRG) (AETC). This organization will:

2.1.17.1. Develop and conduct UTC-specific courses at the request of the MRA and include the topics listed in Table 5.2., as directed in DoDI 1322.24, *Medical Readiness Training*. **Note:** For the CCATT Initial and CCATT Advanced UTC-specific courses, USAFSAM is responsible for developing and conducting UTC-specific courses at the request of the MRA (AMC).

2.1.17.2. Obtain approval of curriculum content for medical readiness training courses and UTC-specific courses from AF/SG through the MRAs, and the RTOC prior to implementation.

2.1.18. Medical Unit Commander. The commander will:

2.1.18.1. Be knowledgeable of assigned unit readiness missions. Annually review and validate assigned UTCs on the AFMS Medical Resource Letter (MRL), ensuring proper reporting in the AEF Reporting Tool (ART), Status of Resources and Training System (SORTS), and Defense Readiness Reporting System (DRRS). (T-0: DoDI 7730.66, CJCSI 3401.02B, AFPD 10-2, CJCSM 3150.01, CJCSI 3401.01)

2.1.18.2. Include input from the MR office in the development of the business plan. (T-2)

2.1.18.3. Support the unit's MR plans program by approving the MCRP for publication after full coordination; establishing and maintaining the capability to provide and/or arrange for emergency care and transport of casualties; and approving installation medical emergency management memoranda of understanding (MOU)/memoranda of agreement (MOA)/mutual aid agreements (MAAs) with military and civilian agencies. (T-1)

2.1.18.4. Establish, assess, and maintain MC-CBRN capabilities and support public health emergency requirements in accordance with AFPD 10-26, Counter-Chemical, Biological, Radiological and Nuclear (C-CBRN) Operations; AFTTP 3-42.32.; DODI 6200.03, Public Health Emergency Management within the Department of Defense; AFI

10-2604; AFI 10-2501; and this Instruction, organically within the medical organization; through written Memorandum of Understanding/Memorandum of Agreement/Mutual Aid Agreement (MOU/MOA/MAA) with other organizations in the local area; or through a combination of these methods. (T-1) Units without the 886I AS, or with less than three assigned laboratory personnel, will maintain the laboratory biological detection capability in accordance with DoDI 6440.03 *DoD Laboratory Network*.

2.1.18.5. Establish an effective medical readiness training program. (T-2)

2.1.18.5.1. Ensure assigned personnel meet mission training requirements in accordance with Area of Responsibility (AOR) reporting instructions, AFI 10-401, AFI 10-403, AFI 36-2201, *Air Force Training Program*, and this Instruction.

2.1.18.5.2. The AFMS acknowledges professional credentialing, practical experience, and other foundational training/education sources may meet the substance and spirit of specific training requirements. The commander must ensure, either through UTC course attendance, exercises, inspections and deployments, or through equivalency credit, that training is conducted for all assigned missions.

2.1.18.5.3. Unit commanders or their designees may grant credit for specific RSVP training tasks that are accomplished as part of regular duties, participation in a deployment or exercise, or attendance at UTC training. For ARC, medical unit commanders may grant credit for specific RSVP training tasks that are accomplished as part of assigned duties at the member's civilian place of employment. Documentation must be provided as evidence for each task credited in this manner.

2.1.18.6. Form and chair the Medical Readiness Committee (MRC). (T-2) MRC meeting frequency and duration must be sufficient to address all necessary agenda items, as listed in Table 2.1.

2.1.18.6.1. AFRC MRC responsibilities are fulfilled through the Executive Management Committee (EMC). ANG MRC responsibilities are fulfilled either through the EMC, Education & Training Committee (E&TC), or a combination of EMC and E&TC. For the purposes of this Instruction, MRC will refer to any committee charged with this function, unless specifically noted.

2.1.18.6.2. Limited Scope (LS) and Limited Scope with Inter-Service Support (LSISS) MTFs may incorporate the MRC into the EMC, as appropriate. If incorporated into the EMC, refer to Table 2.1 to ensure the necessary topics are addressed.

2.1.18.6.3. Deployed MTFs are not required to establish an MRC.

2.1.18.7. Appoint a primary and alternate for each position listed below using MRDSS ULTRA. (T-3) Registering these appointed positions in MRDSS ULTRA will trigger training requirements, if any are associated with the appointed position. Additional written appointment letters are not required unless mandated by other directives or instructions.

2.1.18.7.1. MRO, MRNCO, and/or MRM, as appropriate.

2.1.18.7.2. Unit Medical Readiness Training Manager. For AFRC, designate either the EMC or the Education and Training Committee (E&TC) as the primary oversight

of the medical readiness training function. This oversight is necessary to ensure medical readiness training requirements are scheduled based on the AEF schedule, comply with applicable directives, and are included in the unit's annual training plan. If the E&TC is designated to provide oversight, they will forward to the EMC any issues requiring input or resolution from a higher authority.

2.1.18.7.3. AFSC Functional Training Manager for each assigned AFSC.

2.1.18.7.4. MCRP Team Chiefs.

2.1.18.7.5. Unit Plans Officer/NCO.

2.1.18.7.6. MRDSS ULTRA Unit System Administrator.

2.1.18.7.7. UTC Team Chiefs or UTC Family Group Leaders. Appoint team chiefs and alternates for each assigned UTC or a UTC family group leader and alternate for each group of UTCs. The decision as to whether to appoint team chiefs for individual UTCs or UTC family groups will be at the discretion of the unit commander. UTC family groups may be comprised of multiple copies of the same UTC, as might be the case at a CDM site, or complimentary UTCs (e.g., FFPM1, FFPM2, FFPM3, etc.) based on unit necessity. **Note:** The Patient Decontamination Team, UTC FFGLB, requires the appointment of a UTC team chief and NCOIC. Additionally, Pilot Units are required to appoint team chiefs and alternates for their pilot UTCs.

2.1.18.7.8. Reserve Affairs Liaison.

2.1.18.7.9. For AFRC, an Education and Training office of primary responsibility (OPR). Each unit will appoint in writing an Annual Tour (AT) Monitor and alternate. One of the monitors will be from the full-time medical staff.

2.1.18.7.10. For NDMS-FCC facilities (Not applicable to ARC units):

2.1.18.7.10.1. An FCC Coordinator. This individual is responsible for the management of the day-to-day operations and the alert and activation of the FCC and associated NDMS Patient Reception Areas (PRAs).

2.1.18.7.10.2. An FCC Director (MDG/CC or other principle staff member to whom the MDG/CC has delegated the duty). This individual is responsible for the management and execution of the FCC mission and associated NDMS PRAs in accordance with DODD 6010.22.

2.1.18.7.11. Public Health Emergency Officer (PHEO).

2.1.18.7.12. MTF emergency manager (MEM). The MEM will be the most qualified uniformed service member or DoD civilian employee, in accordance with DoDI 6200.03 Public Health Emergency Management Within the Department of Defense (T-0: DoDI 6200.03) and AFI 10-2604, *Disease Containment Planning*.

2.1.18.8. Fund participation in CCDR-directed operations with appropriations specifically provided to the CCDR for such purposes. Medical units may not use Defense Health Program (DHP) appropriations for CCDR-directed activities.

2.1.18.9. If the MTF maintains WRM assemblages for other units (e.g. RED HORSE, SME, or AE) provide opportunities for those units to train, exercise with and

operationally test the equipment. (T-3) However, the medical unit is not responsible for ensuring that training, exercising and operational testing are accomplished. When possible, these events should be discussed in the MRC/EMC to support project oversight.

2.1.18.10. When the base is host to ARC or other units with similar personnel UTCs, ensure the tenant or supporting units are given the opportunity to train with the host unit's UTCs; ARC Medical units will coordinate training schedules with their AD host MTF. (T-3) Tenant or supporting ARC units are responsible for operationally testing their own equipment, if possessed. Refer questions to the appropriate MEFPK responsible agency (MRA) through the parent MAJCOM.

2.1.18.11. Support public health emergency preparedness by: (T-1)

2.1.18.11.1. Directing medical personnel (e.g., healthcare providers or medical examiner) to promptly report circumstances suggesting a public health emergency to the PHEO. Laboratory reports pertinent to public health emergencies are in addition to routine surveillance systems (e.g., the Electronic Surveillance System for the Early Notification of Community-based Epidemics, more commonly known as ESSENCE), including non-DoD systems and reportable incidents to Public Health in accordance with the Tri-Service Reportable Events prepared by the Armed Forces Health Surveillance Center.

2.1.18.11.2. Ensure PHEOs and MEMs complete required training.

2.1.18.11.3. Upon direction from the installation commander, directing the pharmacy to implement a mass prophylaxis point of dispensing (POD). Designate and train personnel to support mass immunization and prophylaxis POD operations.

2.1.19. Medical Unit MRO, MRNCO, and MRM. These individuals will be referred to collectively as the MR office within this Instruction, unless a paragraph addresses one individual specifically. The MR office will:

2.1.19.1. Develop or provide input to the agenda for MRC/EMC meetings. (T-3) Minimum required agenda topics are listed in Table 2.1.

**Table 2.1. Minimum Required MRC/EMC Agenda Topics.**

Topic	Discussion Items
Training Update	<p>Update on training with assigned WRM; including training opportunities offered to other base medical personnel (para. 2.1.18.10.1.)</p> <p>Status of RSVP training and the gap analysis briefed by AFSC Functional Training Managers (at the discretion of the commander)(para. 2.1.25.5.)</p> <p>Status of medical readiness training by category (chap. 5)</p>

Topic	Discussion Items
MCRP Team Update	Status of team manning, training, equipment and supplies, and an overall assessment of the team's readiness to respond Team equipment and supplies, including MC-CBRN assemblages, inventory results, get well plan, and assessed capability, as appropriate (para. 2.1.23.5.) Increases to MC-CBRN AS levels (para. 3.2.4.5.)
Readiness Status Update	MC-CBRN response capability assessment (para. 3.2.4.2.1.) Latest SORTS, DRRS and ART submission ratings/assessments, and any associated issues, LIMFACs, deficiencies, etc. (classified) MRL changes (when applicable)
Medical Logistics Update	Status of assigned all WRM, including force protection assets such as anti-malaria/cholera program and biological/chemical warfare antidotes, facility expansion assets, etc.
Plans Update	Review and approval of the MCRP (para. 4.1.3.)
Exercise Update	Status of unit, wing/base/installation exercise requirements Exercise credit for real world response (para. 6.4.) Exercise results (para. 6.5.)
UDM Update	MRL changes UTC staffing and overall status Deployment taskings and activities Post-deployment AARs and lessons learned Status of post-deployment RSVP feedback (para. 3.2.1.5.5.)

2.1.19.2. Coordinate and publish the MCRP according to requirements outlined in Chapter 4 of this Instruction. (T-2)

2.1.19.3. Develop, coordinate and maintain copies of medical readiness MOAs/MOUs/MAAs with the supporting off-base agencies. (T-2)

2.1.19.4. Coordinate, schedule, and document in MRDSS ULTRA, UTC-specific training for personnel assigned to UTCs that have courses. (T-0: DoDI 1322.24)

2.1.19.5. Ensure all medical readiness training is properly documented in MRDSS ULTRA in accordance with this Instruction. (T-1) Document UTC sustainment training credit for MRA-approved exercise participation using the exercise end date as the completion date for associated training items.

2.1.19.6. The individual appointed as the MEM will complete the following training:

2.1.19.6.1. Prior to appointment to the position of MEM: (T-1)

2.1.19.6.1.1. Air Force Emergency Management Program Course (AFEMPC) and Air Force Emergency Response Operations: First and Emergency Responders Course (AERO FERC), available through the Advanced Distributed Learning System (ADLS)

2.1.19.6.1.2. Defense Support to Civil Authorities Phase 1

2.1.19.6.1.3. IS 808 Emergency Support Function #8 – Public Health and

Medical Services.

2.1.19.6.1.4. IS 811 Emergency Support Function #11 – Agriculture and Natural Resources Annex

2.1.19.6.2. Complete the following training upon appointment: (T-1)

2.1.19.6.2.1. Public Health Emergency Management (PHEM) course, sponsored by the Defense Medical Readiness Training Institute (DMRTI), within one year of appointment. **Note:** this training expires after five years.

2.1.19.6.2.2. IS 100.HCb Introduction to the Incident Command System for Healthcare/Hospitals

2.1.19.6.2.3. IS 100.b Introduction to Incident Command System (ICS 100)

2.1.19.6.2.4. IS 200.b Single Resources and Initial Action Incidents

2.1.19.6.3. Also complete the following recommended training when time and resources permit:

2.1.19.6.3.1. ICS 300 Intermediate ICS for Expanding Incidents

2.1.19.6.3.2. ICS 400 Advanced ICS, Command and General Staff/Complex Incident (in-residence)

2.1.19.6.3.3. IS 700.a National Incident Management System (NIMS), An Introduction

2.1.19.6.3.4. IS 701.a National Incident Management System (NIMS) Multiagency Coordination System (MACS) Course

2.1.19.6.3.5. IS 775 EOC Management and Operations

2.1.19.6.3.6. IS 800.b National Response Framework (NRF), An Introduction

2.1.19.6.3.7. DSCA Phase 2 (in-residence) course for AF MAJCOM MEMs. Additional guidance for MEMs is provided in AFI 10-2604.

2.1.20. Public Health Officer (PHO) (43HX)/Public Health NCOIC (PHNCO) (4E071/4E091). This individual will (T-0: DoDI 6490.03, DoDI 6490.07, DoDI 6420.01) (**Note:** For AFRC installations, the full-time Bioenvironmental Engineering (BE)/Public Health office is responsible for ensuring full-time public health support to accomplish these requirements):

2.1.20.1. Perform medical intelligence functions.

2.1.20.1.1. In support of wing deployment operations, work with LAF intelligence personnel, National Center for Medical Intelligence (NCMI), and parent MAJCOM Public Health personnel to obtain a medical intelligence assessment to include health threats from infectious disease, poisonous/venomous flora and fauna, disease risks, environmental health hazards, industrial hazards, host nation medical capabilities/facilities, cultural-specific health issues unique to the host nation population, and host nation CBRN warfare medical defense capabilities. Use available medical intelligence sources to prepare the medical threat assessments for deployment locations and to compile medical intelligence/force health protection

briefings for all wing deploying forces during base deployment processing. During the post-deployment phase, provide input to the after action report (AAR).

2.1.20.1.2. For units without a PHO/PHNCO, contact the Command PHO for guidance.

2.1.20.1.3. For AFRC, units tasked with the Aerospace Medicine Function (FFDAF, FFDAG, FFDCC, FFDCD, and FFABC UTCs) will be responsible for this duty in conjunction with their AD Public Health Host. Individuals performing this duty may be assigned to another collocated reserve unit. At AFRC installations, the PH functions are performed by full-time BE/PH personnel, who are aligned under the Mission Support Group or Wing at AFRC host locations.

2.1.20.2. Attend Contingency Preventive Medicine (CPM) Course, #B3OZY4XXX 0B1C, located at USAFSAM, and the Introduction to Medical Intelligence Course located at the NCMI, Ft. Detrick, MD. The Public Health Apprentice, Officer, or NCMI course may be attended in lieu of the CPM Course for ARC personnel performing medical intelligence functions.

2.1.20.3. Serve as a functional advisor to the MR office for planning, training, and execution of the unit installation contingency response program.

2.1.20.4. Perform food vulnerability assessments to support planning and recommended corrective actions in anticipation of, and in response to, an incident. Perform initial testing of foods suspected of deliberate bacterial contamination and collaborate with Office of Special Investigation (OSI), Security Forces Squadron (SFS), Laboratory Biological Detection Team (LBDT), and PHEO to determine an appropriate course of action.

2.1.20.5. Conduct medical surveillance and epidemiological investigations of the installation population and beneficiaries for sentinel events, diseases, and adverse health effects due to CBRN events. Ensure medical surveillance, conducted in accordance with AFI 48-105, *Surveillance, Prevention, and Control of Diseases and Conditions of Public Health or Military Significance* and AFI 10-2603, *Emergency Health Powers on Air Force Installations*, includes baseline health surveillance to assist in detecting a CBRN incident (not applicable to ARC medical units).

2.1.20.6. Conduct MC-CBRN risk communication to provide CBRN incident health risk information to wing personnel and their families.

2.1.20.7. Serve as a POC for the Installation Force Protection Working Group, Threat Working Group, and Vulnerability Assessment Teams.

2.1.21. Bioenvironmental Engineer (BEE) (043E3) or a BE Technician (4B071). This individual will (T-0: DoDI 3020.52, DoDI 6055.17, and DoDI 6490.03) (**Note:** For AFRC installations, the full-time BE/Public Health office is responsible for ensuring full-time support to accomplish these requirements):

2.1.21.1. Serve as a functional advisor to the MR office for planning, training, and execution of the unit's contingency response program.



2.1.21.2. For collocated AFRC units these requirements are to be met by the host BE flight. For non-collocated AFRC units, the full-time BE/Public Health office is responsible for these functions.

2.1.21.3. Serve as a POC for the installation Emergency Management Working Group, Threat Working Group, and the Force Protection Working Group.

2.1.22. Public Health Emergency Officer (PHEO). This individual and alternate will complete the following training:

2.1.22.1. Prior to appointment: (T-1)

2.1.22.1.1. CBRNE Emergency Preparedness and Response Course (EPRC) (clinician/provider) in accordance with paragraph 5.3.3 of this Instruction

2.1.22.1.2. Air Force Emergency Management Program Course (AFEMPC) and Air Force Emergency Response Operations: First and Emergency Responders Course (AERO FERC), available through the Advanced Distributed Learning System (ADLS).

2.1.22.1.3. Defense Support of Civil Authorities (DSCA) Phase 1 training (<http://www.dsca.army.mil/>)

2.1.22.2. Within one year of appointment: (T-1)

2.1.22.2.1. Public Health Emergency Management (PHEM) course, sponsored by the Defense Medical Readiness Training Institute. **Note:** this training expires after five years.

2.1.22.2.2. ICS 300 Intermediate Incident Command System (ICS) for Expanding Incidents

2.1.22.2.3. ICS 400 Advanced ICS Command and General Staff/Complex Incident (in-residence)

2.1.22.3. Also complete the following training when time and resources permit:

2.1.22.3.1. Medical Management of Chemical and Biological Casualties (MMCBC) Course

2.1.22.3.2. Medical Management of Biological Casualties Course

2.1.22.3.3. Medical Management of Chemical Casualties Course

2.1.22.3.4. Medical Effects of Ionizing Radiation Course

2.1.22.3.5. Defense Support of Civil Authorities (DSCA) Phase 2

2.1.22.3.6. IS-701.A NIMS Multiagency Coordination System

2.1.22.4. Additional guidance is provided in AFI 10-2604 for PHEO requirements, including the ANG PHEO Liaison (PHEO-LNO) program.

2.1.23. MCRP Team Chiefs. These individuals will:

2.1.23.1. Prepare and maintain the team's MCRP annex and submit it to the MR office for publication in the MCRP. (T-3) Plan for all installation contingency response scenarios, including incidents with CBRN aspects. Include MC-CBRN procedures and

guidance in the team's MCRP annex and develop checklists that address team response to all potential scenarios. **Note:** this applies to all MCRP teams, not only those with assigned MC-CBRN assemblages. Teams with no MC-CBRN assemblages will address how a CBRN incident might affect team operations and any procedures that may require modification in response to the presence of CBRN elements.

2.1.23.2. Maintain team equipment and supplies, including 886/976 AS, where applicable. (T-2) Waivers for this requirement must be coordinated with the parent MAJCOM/SGX prior to submission in accordance with AFI 33-360. Reference MRDSS ULTRA, Capability Overview, HLD/Customer Owned Assemblages for specific information on these assets. Include in all management activities MC-CBRN responsibilities and assets in accordance with AFI 41-209, *Medical Logistics Support*, and this Instruction.

2.1.23.3. Conduct team training and/or assign trainers, as necessary, to ensure all team members receive training. (T-2) MCRP team chiefs will ensure make-up training is conducted for individuals who miss training events within 60 days of return from leave, deployment, etc. (T-2) See Chapter 5 of this Instruction for specific MCRP team training requirements.

2.1.23.4. Maintain an active MRDSS ULTRA account and document team training for assigned personnel in MRDSS ULTRA or designate a team member to accomplish this task. (T-2)

2.1.23.5. Brief the status of team capabilities to the MRC. (T-3) Included in this update should be the status of team manning, training, equipment and supplies, exercise requirements, and an overall assessment of the team's readiness to respond. Also brief inventory results, get well plan, and assessed capability, as appropriate.

2.1.23.6. LS MTF, LSISS MTF and ARC unit teams identified to support the IEMP 10-2 or equivalent installation emergency management (IEM) plan will prepare and maintain unit response procedures and supporting checklists, based on unit capabilities. Individuals or teams designated to provide medical emergency response support will be trained in accordance with paragraph 2.1.23.3., and this training will be documented in MRDSS ULTRA (see paragraph 2.1.23.4.) and updates provided to the EMC as described in paragraph 2.1.23.5.

2.1.24. UTC Team Chiefs or UTC Family Group Leaders. These individuals will:

2.1.24.1. Ensure UTC members review the UTC Tactics, Techniques and Procedures (TTP), Mission Capability Statements (MISCAPS), Mission Essential Task Lists (METLs), and allowance standards (AS) every 24 months. (T-3)

2.1.24.2. For units possessing WRM assemblages, ensure the appropriate UTC personnel operationally test assigned equipment annually. (T-2) Operational testing will involve team members and is defined as full set-up, turning equipment on, validating that all the necessary pieces are available and in working condition, and re-packing the assemblage.

2.1.25. Unit AFSC Functional Training Managers. AFSC functional training managers at the unit level include enlisted functional managers and the senior officer from each corps (excluding the unit commander). For clinical Biomedical Sciences Corps (BSCs), RSVP

oversight is provided by the SGH (or equivalent), or the SGP at ARC units. These individuals will:

2.1.25.1. Review RSVP checklists to identify training tasks. Conduct or oversee RSVP training, as appropriate, and document it in MRDSS ULTRA. (T-1)

2.1.25.2. Perform a gap analysis anytime RSVP training requirements are updated in MRDSS ULTRA or whenever MTF capabilities change. (T-2) Submit a copy of the gap analysis to the unit MR Office, who will collect and forward all RSVP gap analyses to the parent MAJCOM/SGX. Additional information on the gap analysis is provided in the AF Medical Readiness Guide. Develop a plan to complete all training, including non-local (gap) training items. (T-2) Include RSVP training requirements in the POM.

2.1.25.3. When RSVP checklists are changed, follow implementation guidance provided by the consultant, corps director or CFM. (T-2) If no implementation guidance is provided, training for new tasks must be completed within six months of publication of the new RSVP checklist.

2.1.25.4. Conduct RSVP proficiency verification for personnel tasked to deploy within 90-120 days of their projected departure date, or as soon as possible after deployment notification if less than 90 days. (T-2) Conduct additional training as required to ensure task competency prior to deployment. For tasks that are beyond the unit's capabilities (RSVP gap items), perform a thorough review of associated procedures with the deploying individuals. Document the RSVP proficiency verification in MRDSS ULTRA.

2.1.25.5. Brief the status of RSVP training and the gap analysis to the MRC/EMC at the discretion of the commander. (T-3)

2.1.25.6. Review personnel on-the-job training (OJT) records and IDMT folders, if applicable, prior to each deployment to validate that all required training has been completed and properly documented. (T-2)

**2.2. Additional Roles and Responsibilities.** This chapter captures most of the key roles and responsibilities associated with the medical readiness programs addressed in this Instruction. However, additional responsibilities not mentioned here may be levied by other publications or directives.

## Chapter 3

### MEDICAL READINESS PROGRAM MANAGEMENT

**3.1. The Medical Readiness Office.** The MR office is the hub of readiness activities at the unit level. Personnel assigned to this office manage programs spanning the full range of global medical operations activities. To meet program requirements, there must be a minimum of two full-time personnel assigned to the MR office. For ARC, “full-time” refers to traditional reservists filling the MRO or MRNCO roles. (T-3) Waivers for this requirement must be coordinated with the parent MAJCOM/SGX and Associate Corps Chief for Readiness prior to submission in accordance with AFI 33-360. Two primary positions in the MR office are the Medical Readiness Officer (MRO) and the Medical Readiness NCO (MRNCO). Depending on the size of the facility and the medical readiness program, the MRO may be appointed on a part-time basis. In this instance, a second enlisted member must be assigned to meet the two-person minimum staffing requirement. Whether full or part-time, the MRO must have sufficient time and resources to perform required MRO functions. A DOD civilian Medical Readiness Manager (MRM) may fill either the MRO or MRNCO position in a full-time capacity. LS, LSISS, and deployed MTFs are exempt from the two-person minimum staffing requirement.

3.1.1. Tenure. The MRO, MRNCO and MRM will serve in their positions for a minimum of 24 months, unless reassigned due to a permanent change in station (PCS). (T-3)

3.1.2. Core Competency. Medical readiness is a core competency for the 041AX officers and the 4A0X1 enlisted personnel. Therefore, 041AX medical service corps officers and 4A0X1 healthcare managers should be the primary AFSCs assigned to the Medical Readiness Office. Other individuals may be added to the medical readiness staff as appropriate. For AFRC units only, when 041AX and/or 4A0X1 personnel are not assigned, personnel with any medical AFSC may serve as the MRO or MRNCO. Every effort should be made to avoid assigning additional duties, such as security manager, building custodian, etc., to the MR office staff. Unit level medical readiness positions are not authorized the “R” AFSC prefix. However, MR enlisted personnel may be awarded the 325 special experience identifier (SEI) upon successful completion of the Medical Readiness Management Course (MRMC) and a year of serving in the MR office.

3.1.3. Training. For AC units, all personnel assigned to the MR office (military and civilians) will attend and successfully complete L3OZJ4XXX 00BA, Medical Readiness Management Course (MRMC) before or within six months of assignment. ARC MR office personnel will attend within 12 months of assignment. (T-2) Prerequisites for attending the MRMC includes completing position-specific and UDM training modules in MRDSS ULTRA, provided on the MRDSS training server. The MRMC staff will identify areas not successfully completed to the individuals' home units for additional training and supervision until competency is achieved.

**3.2. MR Appointed Roles.** MRO/MRNCO/MRM responsibilities are discussed in paragraph 2.1.19. of this Instruction and outlined in this chapter.

3.2.1. Unit Deployment Manager (UDM). UDMs have primary responsibility for managing personnel assigned to UTC positions and ensuring those personnel are trained and equipped to accomplish the missions of the UTCs to which they are assigned. Medical UDMs will:

3.2.1.1. Identify personnel to fill UTC positions, in coordination with the unit AFSC functional manager and squadron commanders, using the Control AFSC (CAFSC) for enlisted personnel and Duty AFSC (DAFSC) for officers. (T-2) Ensure the best AFSC and grade skill level match in accordance with AFI 10-403, the UTC Mission Capability Statements (MISCAPs) and other applicable supplemental processing guidance or reporting instructions. Prior to assigning personnel to UTCs and/or selecting individuals to deploy:

3.2.1.1.1. Review Duty Status reports from the Commander's Support Staff (CSS).

3.2.1.1.2. Verify individual duty status and deployment availability (DAV) codes to verify that the individual is present for duty or can be recalled, and that there are no discriminating legal, security, medical, or administrative factors that may render the member ineligible to deploy. Update MRDSS ULTRA with any duty status changes.

3.2.1.2. Assign personnel to UTCs using MRDSS ULTRA and update deployment preparedness information. (T-2)

3.2.1.3. Conduct a UTC orientation for personnel upon appointment to the UTC. The orientation will include a review of the MISCAP, TTP and training requirements. (T-2)

3.2.1.4. Conduct pre-deployment activities. (T-2)

3.2.1.4.1. Upon receipt of a deployment tasking, enter tasked members' anticipated deployment date and estimated tour length in MRDSS ULTRA. Waivers for this requirement must be coordinated with the parent MAJCOM/SGX prior to submission in accordance with AFI 33-360. Update the data if/when changes occur (e.g. if the individual ultimately deploys on a different date or does not deploy) in accordance with paragraph 3.3.4.

3.2.1.4.2. Utilize the AF IMT 4005, *Individual Deployment Requirements*, and AF Form 1098, *Special Task Certification and Recurring Training*, generated by MRDSS ULTRA to prepare AF Deployment Folders (AFDF) in accordance with AFI 10-403 and the Installation Deployment Plan (IDP).

3.2.1.4.3. For units with assigned WRM UTCs, maintain coordination with the Medical Logistics Office to ascertain its capability to deploy and availability of necessary biological and chemical warfare antidotes.

3.2.1.5. Conduct post-deployment activities. (T-2)

3.2.1.5.1. Obtain deployment training documentation from deployers.

3.2.1.5.2. Update MRDSS ULTRA to reflect individual/WRM deployment return date, in accordance with paragraph 3.3.4. of this Instruction.

3.2.1.5.3. Ensure the appropriate MCRP team chief is notified of the need to assess for make-up training.

3.2.1.5.4. Forward requests for RSVP deployment training credit to appropriate AFSC functional training manager for review and recommendations.

3.2.1.5.5. Obtain feedback from deployers (in support of expeditionary, humanitarian assistance, all hazards response or global health engagement operations) regarding the

utility and applicability of RSVP training received in preparation for duties performed while deployed using the RSVP feedback form provided on the AF MR SharePoint Site. Provide completed feedback forms to AFEMSI at: [USAFSAM.ETS.RSVM@us.af.mil](mailto:USAFSAM.ETS.RSVM@us.af.mil), with a courtesy copy to the parent MAJCOM/SGX.

3.2.1.6. Follow applicable UDM requirements as outlined in AFI 10-401, AFI 10-403 and the Installation Deployment Plan.

3.2.2. Unit Plans Officer/NCO. See Chapter 4 for specific planning responsibilities, including coordination of emergency management and contingency MOUs/MOAs/MAAs. Response capabilities and procedures are developed and implemented through publication of the MCRP and input to wing plans. Review all wing plans to ensure medical capability is addressed, on an annual basis, or as required.

3.2.3. MRDSS ULTRA Unit System Administrator. The unit MRDSS ULTRA Unit System Administrator will create user accounts, review and drop/delete unit-level user accounts no longer requiring access, and ensure positive control of sensitive information contained within the system. (T-2) In addition, the System Administrator will:

3.2.3.1. Maintain MR office accounts. Recommend issuing each member of the MR Office staff an individual account.

3.2.3.2. Create and maintain Education and Training (E&T) office accounts. Larger facilities may designate a second MRDSS ULTRA Unit System Administrator in the E&T office to specifically manage E&T accounts. The MRDSS ULTRA Unit System Administrator will provide AFSC functional training managers, MCRP team chiefs, and Graduate Medical Education (GME) directors with MRDSS ULTRA accounts to enter training data for their personnel.

3.2.3.3. Provide assistance to unit users as necessary. Contact the parent MAJCOM MRDSS ULTRA representative for assistance or guidance. The MRDSS ULTRA Unit System Administrator will contact the Help Desk only if the MAJCOM representative is unable to provide assistance.

3.2.3.4. Provide recommendations for updates or changes to MRDSS ULTRA to the parent MAJCOM for consideration by the Configuration Control Board (CCB).

3.2.4. Provide Oversight to the MC-CBRN Program.

3.2.4.1. Manage the utilization of MC-CBRN program funds in conjunction with medical logistics and the resource management office and in accordance with guidance in AFI 41-120 and AFTTP 3-42.32. (T-2)

3.2.4.2. The MRO will coordinate a comprehensive medical response capability assessment which will evaluate the ability of each MCRP team to support wing and medical unit response plans. ANG units shall assess their MC-CBRN teams specifically. (T-2) This assessment will include, as a minimum, a review of wing and medical unit response plans, identification of medical response capabilities required to execute those plans, and an analysis of capability shortfalls. This assessment will also be considered when assessing mission capability in DRRS for AFOP 4.4.3.6., M1.

- 3.2.4.2.1. Response capability assessment will be briefed by the MRO to the MRC (or EMC) at a frequency determined by the medical unit commander. (T-3) Associated team chiefs will participate in the briefing whenever capabilities are degraded. The unit commander will consider this information in assessing the unit's medical emergency response capabilities in DRRS, under AFOP 4.4.3.6., M1.
- 3.2.4.2.2. Medical units will report the results of their response capability assessment to the installation's Emergency Management Working Group (EMWG) and Installation Readiness Council (IRC) annually. (T-3) This allows installation commanders to make informed decisions and take appropriate actions to ensure installation response capabilities are maintained.
- 3.2.4.3. Units that maintain MC-CBRN assets (886 allowance standards (AS) for AFRC and AD units, 976 AS for ANG) will report MC-CBRN/HSMR as a generation mission in MRDSS ULTRA and in DRRS. (T-0: DoDI 7730.66, CJCSI 3401.02B, AFPD 10-2, CJCSM 3150.01, CJCSI 3401.02) Include military members and civilians assigned to MCRP teams in the required, assigned and available numbers.
- 3.2.4.4. Medical units may tailor the baseline capabilities provided by 886 AS by substituting organic or locally leveraged capability in lieu of select 886AS sub-assembly(s). Tailoring does not involve the reduction of levels within a sub-assembly. Tailoring will follow the AF/SG3 approved guidelines, considering local threats, and can utilize local capabilities leveraged through an MOU/MOA/MAA. For ANG collocated units, tailoring of 976 AS is initiated at the unit level and routed through Wing/CC, State Air Surgeon, The Adjutant General (TAG) and to NGB/SGAX for action. Prior to finalizing allowance standard requirements, installation leadership will be briefed on both the medical unit contingency response capabilities and those accessed externally through an MOU/MOA/MAA.
- 3.2.4.5. MTFs assigned MC-CBRN assemblages are not authorized to decrease AS levels but may enhance local capabilities based on threat assessments, medical capabilities and limiting factors. Increases to AS levels must be approved by the MRC/EMC and documented in the minutes. Approved increases will be forwarded to the parent MAJCOM/SG for final approval. EXCEPTION: If assigned, LS and LSISS MTFs may modify 886 AS to provide appropriate capability with HQ ACC/SGXH approval.
- 3.2.4.6. The following guidance applies to ANG units that maintain the MC-CBRN response assets (976AS):
- 3.2.4.6.1. Provide ANG manpower consisting of full-time installation staff who are certified by on-site, formal DoD school, or other training programs as coordinated by NGB/SGAX. (T-1)
    - 3.2.4.6.1.1. 976A - Patient Decontamination Team must have one full-time medic POC and 11 full-time non-medical personnel, as a minimum.
    - 3.2.4.6.1.2. 976H - BE Team will consist of all full-time Bioenvironmental team personnel.
    - 3.2.4.6.1.3. 976K -Triage assembly has no full-time manning requirements.
    - 3.2.4.6.1.4. 976P - Public Health Team will consist of one full-time Public Health

member.

3.2.4.6.2. Execute LAF PE 58036F to fund the ANG MC-CBRN program and coordinate sustainment requirements with NGB/SGAX. (T-2)

3.2.4.6.3. Report inventory results to NGB/SGAX annually. (T-3)

3.2.4.7. The following guidance applies only to non-collocated AFRC units that maintain the MC-CBRN Bioenvironmental Engineering (886H) assemblage:

3.2.4.7.1. The full time Bioenvironmental Engineering office assigned to the MSG owns and is required to maintain the assemblages to accomplish the threat agent surveillance mission (T-1) (N/A to Ft. Worth NAS and Pope AAF).

3.2.4.7.2. For non-collocated AFRC units, 886H assets will be maintained in DMLSS by the host MTF. The host MTF is responsible for establishing the account, ordering supplies and equipment, inputting receivables, and documenting inventory results in DMLSS. (T-0: DODI 3020.52) The supported unit will appoint a unit property custodian (normally BE personnel assigned to LAF units) for the assemblage. (T-0: DODI 3020.52) The property custodian will ensure required inventories are conducted and forward inventory data to the host medical logistics activity, which will complete DMLSS actions and forward inventory documentation to the AFRC unit for completion of the inventory. All actions will be completed within 30 days. (T-0: DODI 3020.52) The property custodian will maintain an MRDSS ULTRA account for assemblage oversight purposes. See AFI 41-209, *Medical Logistics Support*, for additional asset management guidance.

3.2.4.7.3. Funding for 886H equipment/supplies and training is provided through PE 58211F.

3.2.4.7.4. Ensure personnel assigned to the Bioenvironmental Engineering response team designated to use 886H assets are trained based on command guidance and execution of AFTTP 3-42.32 for the 886H AS. (T-0: DODI 3020.52) Reference AFTTP 3-42.32 for specific MC-CBRN requirements and resources for obtaining training.

3.2.4.7.5. All individuals in the AFRC full-time BE/PH office (e.g. where AFRC is the host installation) will be trained to respond using the 886H AS in accordance with Chapter 17 of AFTTP 3-42-32. (T-2) The response force may consist of a combination of BE, public health, civil engineers, or other designated personnel.

3.2.4.7.6. Individuals identified for response will also be trained to perform health risk assessments and to enter the warm/hot zone using Self-contained Breathing Apparatus (SCBA).

3.2.4.7.7. MC-CBRN training will be tracked by the MR office in MRDSS ULTRA.

3.2.4.7.8. Minimum AFRC non-collocated unit MC-CBRN response capabilities (where AFRC is host) will include:

3.2.4.7.8.1. Providing the commander adequate information to make decisions - initial identification and basic assessment only. MOUs/MOAs/MAAs with the local community will provide additional capability.



3.2.4.7.8.2. Responsibilities for biological samples will be to collect, package, ensure chain-of-custody, and transport.

3.2.5. Medical Readiness Program Management Functions. The following functions are also managed by the MR office:

3.2.5.1. Medical Readiness Training. The Unit Medical Readiness Office coordinates, schedules, tracks and documents medical readiness training. (T-1) Units may appoint a Unit Medical Readiness Training Manager to provide a single point of contact for the performance of these functions. Reference Chapter 5 for detailed training information.

3.2.5.2. Readiness In- and Out-processing. Conduct medical readiness in-processing and out-processing in MRDSS ULTRA for assigned personnel. (T-2)

3.2.5.2.1. Establish standardized in-processing procedures for all newly assigned personnel. Develop an orientation checklist to include: MCRP review; UTC assignment and deployment requirements; MCRP team assignment; training requirements; names and duty sections of team chiefs and AFSC Functional Training Manager; and current training status.

3.2.5.2.2. Establish standardized out-processing procedures for personnel permanently changing station, separating or retiring. Print out training data if necessary and provide the individual's AFDF.

3.2.5.3. Provide oversight and support to MCRP Team Chiefs. (T-2)

3.2.5.3.1. Register MCRP team chiefs and assign team members using MRDSS ULTRA.

3.2.5.3.2. Ensure team chiefs know their responsibilities, which include, but are not limited to: maintaining contact information for their team members; developing and maintaining team training lesson plans; ensuring their team members are trained and the training is documented in MRDSS ULTRA; obtaining, maintaining and inventorying team supplies and/or equipment; training team members on use of assigned supplies and/or equipment; reviewing and updating the team's annex in the MCRP as well as supporting operational checklists. Include in all management activities MC-CBRN responsibilities and assets in accordance with AFI 41-209, *Medical Logistics Support*, and this Instruction.

3.2.5.4. Minimum Weapons Requirements. Weapons authorizations for medical UTCs are provided on the AF Medical Readiness SharePoint Site.

3.2.6. Pilot Unit Liaison. At MTFs with pilot unit responsibilities, the MR office will maintain pilot unit program management oversight and act as liaison to the MRA. (T-2)

**3.3. Medical Readiness Decision Support System Unit Level Tracking and Reporting Application (MRDSS ULTRA).** MRDSS ULTRA provides enhanced global visibility of medical materiel, personnel, and their training to allow for the efficient management and deployment of those assets. MRDSS ULTRA is the official system of record for the management of expeditionary medical personnel and resources for the AFMS and will be used by the Medical Readiness Office. It is the single authoritative source of readiness training data for medical personnel and UTC apportionment through the MRL. The governing directive for MRDSS ULTRA is this Instruction.

3.3.1. Access. Only authorized medical personnel and units, and others requiring access for official use, are granted access to MRDSS ULTRA. The data it contains will not be released nor provided outside the AFMS or supporting agencies without prior approval by appropriate level command authorities. The MRO/MRNCO/MRM and MRDSS ULTRA Unit System Administrator will contact the MAJCOM SGX POC to obtain an account, as well as MAJCOM-specific usage guidance. Other unit personnel, including E&T personnel and all MCRP team chiefs will contact the MRDSS ULTRA Unit System Administrator to obtain accounts. **Note:** The MRDSS Help Desk does not establish user accounts without authorization from MAJCOM or higher headquarters.

3.3.2. Classification. The data contained within MRDSS ULTRA is for official use only (FOUO). Although it contains the raw statistical data used to compile classified operational readiness reports, it does not contain, report, collect, or display all the data elements for a UTC, nor does it include supporting remarks or allow for unit commander assessments of the ability of a UTC or MCRP team to perform its specific mission.

3.3.3. Medical Resource Letter (MRL). The MRL, maintained within MRDSS, is the tool designed to manage AFMS readiness resources. Information provided in the MRL for a specific unit includes, but is not limited to: UTCs currently apportioned to the unit; UTCs the unit is projected to gain or lose over the next five years; whether assigned UTCs are manpower or equipment; AEF assignments for each UTC; UTC availability codes; and additional information for equipment UTCs. In addition, the MRL is utilized to manage the apportionment/distribution of MC-CBRN assemblages (886 AS), using pseudo UTCs HSMRA through HSMRP.

3.3.4. Data Currency. The MR office will ensure the currency of MRDSS ULTRA data at all times and update it as events or changes occur. (T-2) Waivers for this requirement must be coordinated with the parent MAJCOM/SGX prior to submission, in accordance with AFI 33-360. Updates include the following, at a minimum: annotating training events, UTC assignments, MCRP team assignments, DAV codes, and unit information such as contact information for medical readiness and medical logistics staff (phone numbers, e-mail addresses, classified communication device numbers, and 24-hour contacts).

3.3.5. MRDSS ULTRA Functions. Units use MRDSS to:

3.3.5.1. Assign appointed positions, such as MRO/NCO/MRM, UDM, Unit Functional Training Managers, etc.

3.3.5.2. Assign personnel to UTCs and MCRP teams.

3.3.5.3. Track readiness training completion including, but not limited to, UTC formal courses, MCRP team training and RSVP.

3.3.5.4. Track personnel and WRM deployments.

## Chapter 4

### MEDICAL CONTINGENCY RESPONSE PLAN

**4.1. Medical Contingency Response Plan (MCRP).** The MCRP is the medical unit commander's plan, establishing procedures for the unit's expeditionary missions identified in the Designed Operational Capability (DOC) statement and emergency response missions identified in the IEMP 10-2. The MR office will manage the preparation, coordination, publication, and distribution of the MCRP. (T-2) The annexes in Table 4.1 will be included in all published MCRPs. (T-0) Additional annexes and guidance may be included as necessary, based on the MTF's mission and capabilities. Reference the AF Medical Readiness Guide for additional information.

**Table 4.1. Required MCRP Annexes.**

Annex	Includes:
A - General Instructions	Information applicable to all MTF personnel regardless of team assignment. Included is information on recall procedures, space allocation during contingency operations, and supporting plans and agencies. This annex also describes: - Medical Continuity of Operations (COOP) procedures in accordance with paragraph 4.1.2. Plans for sheltering in place, within the facility, and evacuation to an external designated shelter for an imminent, more extended incident, such as a hurricane.
B - Medical Command and Control	Requirements for medical transportation and personnel support during a Medical COOP incident, as well as operations recovery and reconstitution procedures following the incident. Procedures for managing and deploying UTCs apportioned in the MRL.
C – Field Response Team	Initial medical response and any follow-on medical emergency response to the scene as requested by the incident commander and is responsible for assessing the situation, requesting additional support as necessary, and providing triage, treatment and stabilization on-scene. Procedures for use of the 886J assemblage for MC-CBRN response

Annex	Includes:
D – Patient Support and Casualty Management	<p>Maximum anticipated patient population during contingencies, projected changes in availability of medical services, including curtailment of routine services, and patient redistribution.</p> <p>Casualty management for each respective team/work center, to include casualty flow within the facility and transportation of casualties to the MTF and other facilities. Outline procedures to respond to all contingencies.</p> <p>Procedures for use of the 886L and 886D assemblages for MC-CBRN response and SG05 Pandemic Influenza Supplies.</p> <p>The facility's AE role, including procedures to be used in the event of an unanticipated diversion of AE missions to the base, or the unplanned requirement to support patients, both inpatient and outpatient, remaining overnight.</p>
E – Triage Team	<p>Triage patients arriving at the medical unit (primary team) and a similar team to provide re-triage after patient decontamination (secondary team).</p> <p>Procedures for use of the 886K assemblage for MC-CBRN response.</p>
F – Laboratory Team and Laboratory Biological Defense Team (LBDT)	<p>Diagnostic laboratory services in support of contingency operations. Identifies biological agents of operational concern in environmental and clinical samples.</p> <p>Procedures for use of the 886I assemblage for MC-CBRN response.</p>
G – Pharmacy Team	<p>Procedures to request assets from the Strategic National Stockpile (SNS) (in CONUS) or established overseas stockpiles.</p> <p>Mass prophylaxis distribution processes.</p> <p>Procedures for use of the 886E assemblage for MC-CBRN response and management and use of SG06 Pandemic Influenza Pharmaceuticals.</p>
H – Patient Decontamination Team	<p>Procedures for patient decontamination prior to entry into the MTF or transport to another medical facility.</p> <p>Procedures for use of the 886A assemblage or a permanent fixed decontamination facility, if available</p>
I – Patient Administration Team	<p>Patient administration functions during all contingency scenarios, including Medical COOP.</p> <p>Patient tracking and status reporting of casualties within the facility and those transported to other area medical facilities</p>
J – Disaster Mental Health (DMH) Team	<p>Guidance for mental health services to patients and families in support of disaster response operations. Hostage negotiation consultation requirements as well as support for First and Emergency Responders.</p> <p>Reference AFI 44-153, <i>Traumatic Stress Response</i>, for additional guidance.</p>
K – Public Health Team	<p>Public health needs assessment procedures; communicable and vector-borne disease surveillance, prevention, control, and reporting; food safety and decontamination oversight; food borne illness outbreak investigations and food vulnerability assessments; health threat assessments; and deployment health threat management and education.</p> <p>Procedures for use of the 886P assemblage for MC-CBRN response.</p>

Annex	Includes:
L – Bioenvironmental Engineering (BE) Team	Evaluating environmental and occupational health hazards and recommended actions for control of these hazards; monitoring of base water supply to ensure potability, safety, and survivability (if applicable); monitoring, evaluation, and direction for control of chemical, biological, and radiological hazards; and assistance provided in selecting base and unit shelters. Procedures for use of the 886H assemblage for MC-CBRN response.
M – Medical Logistics Team	WRM management, maintenance requirements, distribution of drugs and support to MC-CBRN teams. Describes logistics recovery and reconstitutions procedures following a Medical COOP incident.
N – Manpower and Security Team	Procedures for supporting wing/base terrorist threat response and in carrying out Force Protection Condition actions within and around the MTF. Deployment and management of manpower team members during an emergency. Manpower and Security Decontamination Support Team procedures and required training. <b>Note:</b> this is a sub-team of the Manpower and Security team, specifically designated and trained to support patient decontamination operations (see Annex N). Procedures for use of the 886M assemblage for MC-CBRN response.
O – Facility Management Team	Facility management response to contingency events, to include oxygen, HVAC, and utilities emergency shut-off procedures and locations. Relationships and communication procedures with the Security and Manpower Teams during building evacuation, force protection condition response, or patient/public movement control or restrictions within and around the facility. Facility reconstitution procedures following a catastrophic incident that renders the MTF uninhabitable, such as a Medical COOP situation.

#### 4.1.1. Special Planning Considerations.

4.1.1.1. LS, LSISS, and deployed MTFs are not required to prepare an MCRP. However, these units will conduct a realistic assessment of their contingency response capabilities (including MC-CBRN) and incorporate them into the IEMP 10-2, or sister service equivalent. (T-2) ANG units will include 976 Program Elements, to include team composition, and training requirements, at a minimum. (T-2) Use the MCRP team annex guidance in table 4.1 as the framework for preparing the unit's emergency/disaster response input, utilizing the established MCRP team names where applicable. Clearly identify MTF capabilities, roles and responsibilities in support of a collaborative installation response, including support provided via MOUs/MOAs/MAAs, as appropriate. Ensure assigned personnel are trained and record this training in MRDSS ULTRA utilizing existing MCRP team names. Local MCRP team training requirements may be added to allow for tracking of unit-unique training.

4.1.1.2. ARC and Aeromedical Evacuation (AE) units collocated with an AC MTF are considered available medical resources and will be included in the AC MTF's MCRP as such.

4.1.1.3. Depending on local support available, particularly for OCONUS units, support may be provided by another AF MTF. When this is the case, support to be provided will be included in the supported IEMP 10-2 and be addressed in the supporting MTFs MCRP.

4.1.1.4. Units will develop and maintain current medical emergency response checklists in support of installation plans, addressing unit control center activation, major accident response, natural disaster response, MC-CBRN response, and casualty management, at a minimum. (T-2) In addition, deployed MTFs will include attack response as a potential scenario.

4.1.1.5. Units in multi-service or multi-unit areas, e.g. San Antonio or Colorado Springs, will develop an integrated MCRP, addressing a unified response to a city-wide event or incident as well as interaction between units and with local emergency management officials. (T-2)

4.1.2. Medical Continuity of Operations (COOP). Medical COOP involves the evacuation and dispersal of patients from the MTF as rapidly and safely as possible, staging them in a pre-designated location and providing necessary medical care only until dispersal activities are complete. Medical COOP does not involve relocating vast amounts of supplies and personnel to an alternate location for the purpose of continuing routine patient care, although units that have the capacity or responsibility to continue to provide services to AD base populations may plan to do so.

4.1.2.1. For Medical COOP, the core mission essential functions (MEF) to be addressed in the MCRP include: 1) medical command and control for the evacuation and dispersal; 2) patient support, to include facility evacuation, dispersal, transportation, tracking, and pandemic response, at a minimum; 3) staff support, to include evacuation, dispersal, and accountability; 4) medical emergency response activities, to include critical installation support; 5) Command, Control, Communications, Computers and Information (C4I), to include relocation and continuity of medical command and control, as well as information sharing with beneficiaries, staff, and higher headquarters. Units may add additional MEFs based on their unique missions, capabilities, and beneficiary population needs. List and prioritize all MEFs in the MCRP.

4.1.2.2. The Information Services Disaster Response Team (ISDRT) supports Medical COOP operations by reacting to disasters or downtime, preventing, and detecting data loss or compromise from further intrusion, recovering and maintaining IS, and coordinating with outside agencies to restore critical systems. Team responsibilities include assessing damage to IS hardware, software, and data; notifying various agencies (Air Force Computer Emergency Response Team (AFCERT), MAJCOM, Legal, Public Affairs, etc.) as required; ensuring the MTF meets current Information Operations Condition (INFOCON) levels checklists; denying access to or shutting down vulnerable systems; and maintaining and prioritizing a list of critical systems and associated administrators of those systems.

4.1.2.3. See AFI 10-208, *Air Force Continuity of Operations (COOP) Program*, for additional non-medical specific guidance.

4.1.3. Plan Coordination. All offices and agencies tasked to provide any kind of support in the MCRP must coordinate on the plan, specifically approving their roles and responsibilities. (T-2) Submit a copy of the draft MCRP to the parent MAJCOM/SGX for review after full coordination with applicable agencies and MRC/EMC approval, but prior to publication. Plan reviews will be accomplished by MAJCOM/SGXs within 60 days. Concurrence is implied if no comments from the MAJCOM are received within that period.

4.1.4. Plan Review. Review the MCRP and supporting checklists annually for currency and make changes as necessary. (T-3) Coordinate changes with all affected agencies and distribute according to the original plan distribution. The MCRP will be rewritten when there is a significant mission change, or when the volume of changes exceeds 10% of the document (by page count). (T-2) Update the MCRP publication date in MRDSS ULTRA whenever the plan is re-published.

4.1.5. Plan Distribution. Distribute copies of the MCRP and appropriate checklists to each office that plays a role in its execution. The MR office will maintain additional copies for transfer to the shelter, Medical Continuity of Operations (COOP) alternate command and control (C2) location, and the installation EOC, as applicable. (T-3) Provide a copy of the final published MCRP to the parent MAJCOM/SGX.

**4.2. Memorandums of Understanding (MOUs), Memorandums of Agreement (MOAs), and Mutual Aid Agreements (MAAs).** Support to the MTF from off-base agencies must be coordinated in writing, in the form of an MOU, MOA, or MAA, in accordance with AFI 25-201, *Support Agreements Procedures*. (T-2) Do not duplicate existing agreements and contracts, such as the TRICARE contract. Approval of the MOU/MOA/MAA constitutes agreement with the plan contents, therefore an additional staff summary sheet is not required. If unable to obtain coordination with an off-base agency, develop a memorandum for record (MFR) and attach all correspondence (e-mails, memos, phone records, etc.) to document their attempts to gain formal coordination.

## Chapter 5

### MEDICAL READINESS TRAINING

**5.1. Training Philosophy.** All medical personnel must be fully trained to meet the task requirements associated with home station and global operations. A list of training requirements that may be met through attendance of formal courses, such as the Expeditionary Medical Readiness Course (EMRC), Basic Expeditionary Medical Readiness Training (BEMRT) and Commissioned Officer Training (COT), is provided on the Medical Readiness Training Equivalency Matrix on the AF Medical Readiness SharePoint Site in the AFI 41-106 Toolbox.

5.1.1. Initial Training. All Airmen, regardless of rank, fill a duty AFSC (DAFSC). Airmen are trained to initial proficiency upon entry into the Air Force, or join the Air Force with verifiable AFSC-specific credentials. Enlisted personnel receive initial medical readiness training through EMRC or BEMRT in conjunction with their AFSC-awarding courses. Officers receive initial medical readiness training as part of COT or Reserve Commissioned Officer Training (RCOT) courses, or through a commissioning program such as a service academy, Reserve Officer Training Corps (ROTC) or Officer Training School (OTS). Curricula for these courses will provide the initial medical readiness training elements listed in Table 5.1., at a minimum.

**Table 5.1. Initial Medical Readiness Training Topics.**

Training Element	Description
AEF Concept/Structure	Familiarization of current Air Expeditionary Force concepts
Joint Operability Concept	Introduction to what other services do
The Deployment Cycle	Phases of deployment, pre-deployment, initial deployment, build up, sustainment, termination/re-deployment
AFMS Concepts of Operations (CONOPS)	AFMS Mission, DoD Medical Service Capabilities, Medical Support of Stability Operations, Homeland Defense and Defense Support of Civil Authorities (DSCA), threats and potential battlefield environments (including site security to include Law of Armed Conflict and Geneva Conventions, force protection, anti-terrorism measures), and awareness of homestation response (MCRP) mission
Combat Stress Control	Signs and symptoms of stress, treatment and assistance
Casualty Movement	Casualty evacuation concepts, litter carries, AE familiarization
CBRN Defense Awareness and Skills Training	Reference AFI 36-2201
Shelter Assembly	Procedures for unpacking the shelter system, erecting the shelter system, striking the shelter system, procedures for re-packing the shelter system, procedures for site clean-up
Field Sanitation and Hygiene, Disease Prevention	Occupational and environmental hazards, disease types and countermeasures, types of waste and their disposal, force health surveillance



5.1.2. Collective Training. Collective Training is defined as the training of a group of Airmen, such as MCRP teams or UTCs on the performance of tasks performed as a whole. This includes multiple training platforms operating concurrently at the same place and time.

5.1.3. Training Categories. Medical Readiness training requirements identified in this Instruction are grouped as Category I, II or III. Individual training requirements are classified as Category I and are required for all medical personnel, and in some cases assigned non-medical personnel, civilians, and contractors, regardless of their deployment status. Category II includes training required for medical personnel assigned to standard deployable UTCs. Medical personnel must complete all Category I and II training before entering their deployment vulnerability period. (T-0: DODI 1322.24) Completed training will remain current for the duration of the vulnerability period or associated deployment, regardless of duration. Category III consists of MCRP team training and is accomplished at the unit level for all assigned personnel.

5.1.4. Limited Scope (LS) and Limited Scope with Inter-service Support (LSISS) MTFs. LS and LSISS MTFs will conduct Category III: Unit Training – MCRP Team Training, based on unit capabilities and support they are required to provide. (T-1) If the unit has personnel assigned to standard UTCs, Category I and II training is required for those individuals. Regardless of UTC of assignment, any LS and LSISS MTF personnel tasked to deploy will complete Category I and II training prior to deploying. ARC units are considered LS MTFs.

5.1.5. Life Support Training. Personnel holding certain clinical AFSCs who are assigned to standard deployable UTCs may be required to maintain currency in Basic Life Support (BLS), Advanced Trauma Life Support (ATLS), Advanced Cardiac Life Support (ACLS), National Registry of Emergency Medical Technicians (NREMT), Prehospital Trauma Life Support (PHTLS), or other life support training, in accordance with AFI 44-102, *Medical Care Management*.

5.1.5.1. Required life support training must remain current throughout any projected deployment vulnerability period and will not lapse during a deployment. Training or certifications that are due to expire during an individual's vulnerability period must be reaccomplished prior to entering the vulnerability period to ensure currency.

5.1.5.2. Education and Training (E&T) office personnel will validate requirements for each specialty and track this training in MRDSS ULTRA. (T-1) Representatives from the E&T office will be given MRDSS ULTRA accounts for this purpose. Larger facilities may designate a second MRDSS ULTRA Unit System Administrator in the E&T office specifically to manage E&T accounts.

5.1.6. Training While Deployed. Personnel are required to be fully trained prior to deployment. Therefore, deployed units are not expected to conduct medical readiness training. However, personnel should take full advantage of any training opportunities provided, to include joint training with coalition partners, sister services, host nation medical forces, and others. Upon return to home station, members may request credit for training accomplished during deployment in accordance with this Instruction.

5.1.7. Personnel in Non-standard Training Situations.

5.1.7.1. Interns, residents, students, including those enrolled in Health Professions Scholarship Program (HPSP) or other residency or internship programs, as well as personnel in fellowship training status, are exempt from medical readiness training unless tasked to deploy or assigned to a standard UTC or MCRP team. However, participation in local training and exercises is highly recommended when opportunities are available.

5.1.7.2. Recognizing all medical personnel must maintain a baseline training standard, medical personnel assigned to non-medical units will complete the Category I requirements in this chapter, as well as specialized training for their unique medical missions. (T-1) MAJCOM/SGXs may facilitate training by pairing these units with a larger MTF, if necessary.

5.1.7.3. Medical Institutional Force (IF) personnel (those assigned to higher headquarters, such as MAJCOMs and the Air Staff) will complete the Category I and Category II requirements identified in this chapter when assigned to a standard deployable UTC or tasked to deploy. Category III training is not required for IF personnel. A unit training monitor will be appointed to schedule, track and document staff training.

5.1.7.4. Chaplain Service personnel assigned to an MTF are encouraged to participate in medical readiness training. The MR office will coordinate with the senior chaplain to schedule this training.

## 5.2. Training Documentation.

5.2.1. MRDSS ULTRA. All medical readiness training, including equivalency training credit (as applicable) is documented in MRDSS ULTRA for:

5.2.1.1. Assigned unit personnel, ensuring personnel deploying as substitutes outside their assigned UTCs receive required training for the tasked UTC. (T-2)

5.2.1.2. IMAs that are attached to the unit. Assign IMAs to the FFAZZ Associate UTC in MRDSS ULTRA for tracking purposes. They will not count against unit training statistics.

5.2.1.3. Other medical personnel on or off base who do not work within the medical facility (e.g. Squadron Medical Element (SME) personnel). These individuals should be tracked by associating their unit's Personnel Accounting System Code (PASCODE) with the MTF within MRDSS ULTRA. For remotely located medical personnel (e.g. recruiters), the nearest MTF will assume responsibility for tracking their training. Doing so will not affect MTF training statistics. Obtain the PASCODE for the unit to be associated and contact the help desk for assistance. If coordination of training events or dates with these units is not successful, document associated communications in a memorandum for record. **EXCEPTION:** AF Special Operations Command (AFSOC) Operational Support Medicine (OSM) flights and AFSOC medical personnel assigned to Special Tactics Groups/Squadrons (STG/STS) track their own training in MRDSS ULTRA.

5.2.2. Air Force Training Record (AFTR). Prior to an enlisted member's deployment to an AF overseas contingency operation, the unit AFSC functional manager must review and print the member's RSVP checklist and individual AF Form 1098 in MRDSS ULTRA, ensuring

all training requirements have been completed and properly documented. (T-1) Upload these documents into the member's AFTR following the review. Upon the member's return to homestation, the functional manager will determine if any relevant training was accomplished during the deployment and, if so, document it in AFTR and upload any AF Form 1098s/AF Form 623a provided. (T-1)

**5.3. Category I: Individual Training.** Individual training is a broad categorization that consists of core individual level training. Category I training begins and is counted in unit training statistics upon personnel in-processing to their first duty station. Category I training consists of the Readiness Skills Verification Program (RSVP), Sustainment of Trauma and Resuscitation Skills Program (STARS-P), and CBRNE Emergency Preparedness and Response Course (EPRC).

5.3.1. Category I: Individual Training - RSVP. RSVP training applies to all individuals who hold a medical AFSC. It represents or establishes minimum baseline AFSC skills required to perform a critical task in a medical deployment environment. Personnel who are tasked to deploy in a non-medical (non-AFSC) capacity (e.g. staff liaison, TCN-duty, etc.) are not required to complete RSVP for their AFSC prior to deploying.

5.3.1.1. RSVP training should begin as soon as personnel arrive at their first duty station, in accordance with guidance provided by the consultant, corps director or CFM for each specialty, with credit awarded as applicable for skills learned in technical training or professional education. For ARC units, RSVP training begins when an individual returns to the unit after completion of their 3-level AFSC-awarding technical school. Ideally, personnel should complete their RSVP training before they enter their deployment vulnerability period to ensure they are ready for deployment at any time. However, RSVP training must be complete and proficiency verified before the individual deploys. RSVP checklists can be accessed within MRDSS ULTRA or through the AF Medical Readiness SharePoint Site. The governing directive for RSVP is this Instruction.

5.3.1.2. Personnel will complete RSVP training for their Control AFSC (CAFSC) for enlisted and Duty AFSC (DAFSC) for officers. (T-1) Waivers for this requirement must be coordinated with the AF/SG specialty consultant, corps director or CFM prior to submission, in accordance with AFI 33-360.

5.3.1.2.1. Personnel who are utilized as authorized substitutes on a standard UTC must complete RSVP training for the AFSC they are filling on the UTC, as well as their own AFSC. (T-1) Exceptions to this policy must be approved by the specialty consultants, corps directors or CFMs of both AFSCs.

5.3.1.2.2. For the Patient Decontamination Team, UTC FFGLB, authorized substitutes will complete RSVP training for their own AFSC only.

5.3.1.3. Institutional Forces and personnel assigned to LS or LSISS MTFs may accomplish RSVP just-in-time (JIT), upon receipt of a deployment tasking, unless otherwise directed by the specialty consultant, corps director or CFM. However, all RSVP training is completed and proficiency verified prior to deployment.

5.3.1.4. Contact the appropriate consultant, corps director or CFM to determine RSVP requirements for commanders on G series orders (non-temporary).

5.3.2. Category I: Individual Training - STARS-P. STARS-P is designed to maintain the clinical currency of trauma and resuscitative skills of medical personnel assigned to specified MTFs by regular immersion in on-going clinical rotations at nearby civilian Level-1 trauma centers. By utilizing a core curriculum and advanced human patient simulators, teams may be trained and qualified at a STARS-P platform.

5.3.2.1. STARS-P participants may include AFSCs listed on the C-STARS Training Matrix, as well as other eligible members assigned to the MTF.

5.3.2.2. Participating personnel will regularly rotate through the STARS-P location throughout the year, unless they are deployed, TDY, or on leave. (T-1) Rotations will be considered part of normal duty.

5.3.2.3. To provide currency, STARS-P platforms must provide minimum individual currency events and objectively evaluated team-based trauma resuscitation training and testing curriculum. Simulator facilities will be utilized for team-based trauma resuscitation and stabilization training, and for individual procedural-based skills training, when the procedure is not completed during ward rotations.

5.3.2.4. Individuals who are required to attend C-STARS and are actively participating in STARS-P programs will apply for a C-STARS exemption every 24 months. (T-1)

5.3.2.5. STARS-P is not an authorized substitute for the CCATT Advanced Course required for FFCCE, FFCCN, FFCCT, or FFQE4 personnel. These members must follow requirements prescribed in this Instruction.

5.3.2.6. STARS-P participation will be documented in MRDSS ULTRA.

5.3.3. Category I: Individual Training - CBRNE EPRC. CBRNE EPRC is required for all DOD medical personnel as well as all non-medical personnel working in or assigned to an MTF. AFMS new accessions are required to accomplish CBRNE EPRC within 12 months of arriving at their first duty station. Sustainment training must be completed every 36 months. (T-0: ASD HA Policy Memo, 9 Jan 04) Depending on an individual's AFSC and duties, they will complete one or more of the four CBRNE EPRC courses described below and ensure that their training is documented in MRDSS ULTRA. The requirements for completing Medical Effects of NBC Warfare and Threat and Future Battlefield training prescribed in DODI 1322.24, *Medical Readiness Training*, as well as Depleted Uranium training are met through completion of Clinician/Provider or Operator/Responder CBRNE EPRC. CBRNE EPRC is accomplished on Joint Knowledge Online (JKO) at: <https://jkodirect.jten.mil>.

5.3.3.1. Clinician/Provider Course. This course is required for all personnel with a physician, nurse, dentist, physician assistant or IDMT primary AFSC (PAFSC).

5.3.3.2. Executive/Commander Course. This course is required for personnel filling a C-prefix (commander), or having a 40C0 or 9G100 (group superintendent) duty AFSC. Personnel will be granted credit for the Executive/Commander course if they have completed either the Clinician/Provider or Operator/Responder courses, as appropriate for their PAFSC. Individuals in these roles do not have to take another EPRC course until/unless they are reassigned to a non-command position. Once reassigned, they must also complete the course appropriate for their AFSC within 120 days of reassignment.

Unit Medical Readiness Training Managers will ensure commanders' duty AFSCs are appropriately entered in MRDSS ULTRA and updated as necessary.

5.3.3.3. Operator/Responder Course. This course is required for all personnel holding a medical PAFSC who do not meet the criteria in paragraph 5.3.3.1. for the Clinician/Provider and Executive/Commander courses. Personnel assigned to the MR office must also take the Operator/Responder course, regardless of their PAFSC.

5.3.3.4. Basic Course. This course is required for all personnel holding a non-medical AFSC (e.g. 3S2XX, 8F0XX) but working in a medical unit or medical staff position.

5.3.3.5. Medical Civilian and Contractor Personnel. Civilian and contractor personnel will take the same course(s) as military members in their positions. For example, a contractor dentist would complete the Clinician/Provider course. Training for these individuals is also tracked in MRDSS ULTRA.

**5.4. Category II: Deployment Training.** Category II training includes UTC-specific training and human remains preservation training. Additional training, such as Medical Ethics and Detainee Operations Training may be required for some deployers through deployment line remarks. Course descriptions and guidance are provided below. Medical-specific information regarding the Law of Armed Conflict is provided in Attachment 2 of this Instruction and should be used to supplement Law of Armed Conflict (LOAC) training accomplished through the Advanced Distributed Learning Service (ADLS) per AFI 36-2201, *Air Force Training Program*.

5.4.1. Category II: Deployment Training – UTC-Specific Training. Personnel assigned to deployable UTCs will complete UTC-specific training in accordance with the following paragraphs. In the case where a member has an opportunity to participate in a sustainment training platform, prior to attendance at the formal/initial course, UTC-specific training credit may be requested through the parent MAJCOM/SGX to the appropriate MRA/SGX for approval. Personnel granted such credit must attend the UTC formal course during their next training cycle.

5.4.1.1. Personnel who are not assigned to a standard deployable UTC but are tasked to deploy in a standard UTC, must complete UTC-specific training for the tasked UTC position. (T-0: DODI 1322.24)

5.4.1.2. Credit for UTC formal training is provided only by attending the UTC formal courses. For UTCs that do not have UTC-specific courses, training will consist of reviewing the UTC Tactics, Techniques and Procedures (TTP), Mission Capability Statements (MISCAPS), Mission Essential Task Lists (METLs), and allowance standards (AS) every 24 months. (T-2)

5.4.1.3. UTC sustainment training is accomplished between formal course attendance cycles and is designed to keep UTC members' skills current.

5.4.1.4. UTC-specific course curricula will include the medical readiness training elements listed in Table 5.2. at a minimum, in accordance with DoDI 1322.24, *Medical Readiness Training*.

**Table 5.2. Medical Deployment Training Topics.**

Training Requirement	Description
Threats and potential battlefield environments.	Includes disease prevention and field sanitation and hygiene
Operational concepts of operation.	AFMS Mission, DoD Medical Service Capabilities, Medical Support of Stability Operations, Homeland Defense and Defense Support of Civil Authorities (DSCA), Threats and Potential Battlefield Environments, Awareness of homestation response (MCRP) mission
Operational command, control, and communications.	Activities that use information and business management systems to facilitate day-to-day operations in support of operational missions, including the use of radio communications, Information Management/Information Technology (IM/IT). Review AFTTP 3-42.1, <i>Health Service Support Command and Control in Deployed Operations</i> , and AFPAM 10-100, <i>The Airman's Manual</i> .
Preventive medicine, including field sanitation and hygiene.	Personal hygiene, food and water handling, waste disposal (human and medical), and other medical responsibilities. Operational measures for countering endemic disease, prevention of non- battle injuries, mental health, countering disease vectors in field and urban environments, environmental health threats, and force health surveillance will be covered.
Occupational and environmental hazard recognition, mitigation, and reporting.	Public Health/Bioenvironmental personnel accomplish site selection surveys and travel to off-site locations to evaluate a market setting and village setting to conduct surveys on food, water, and health concerns.
Combat stress control (CSC)	Familiarization with basic principles of CSC management, as well as leadership, communication with troops, unit morale and cohesion and individual psychosocial stressors, before, during and after deployment.
Identification and treatment of endemic infectious diseases.	Public Health and International Health Specialist (IHS) personnel review Medical Intelligence Report on deployed location and make recommendations to commander and medical staff on immunizations and prophylaxis prior to deployment.
Identification and treatment of traumatic injuries.	Clinical aspects of medical management of casualties and disease non- battle injuries, particularly triage and initial evaluation; gunshot wounds; vascular, neurological, orthopedic, maxillofacial, and hypo/hyper thermal stress injuries; burns, bandaging, and splinting; hypovolemic shock; eye injuries; and use of blood products.

Training Requirement	Description
Medical support of stability operations, humanitarian assistance activities, homeland defense and defense support of civil authorities.	AFMS Mission, DoD Medical Service Capabilities, Medical Support of Stability Operations, Homeland Defense and Defense Support of Civil Authorities (DSCA), Threats and Potential Battlefield Environments, Awareness of homestation response (MCRP) mission
Recognition and medical management of chemical, biological, radiological, nuclear, and explosive injuries.	Clinical staff is trained to recognize types of injuries/illnesses during triage, upon presentation to the field clinic, and then establish procedures to manage the patient throughout the facility in a safe, effective manner during a field exercise.

5.4.1.5. Personnel assigned to standard UTCs who have attended UTC-specific training will remain on that UTC for a minimum of 24 months, or until they PCS, whichever is soonest. (T-2)

5.4.1.6. Procedures for scheduling ARC personnel for UTC-Specific training are as follows:

5.4.1.6.1. For ANG units, UTC formal training will be scheduled through the NGB/SGAX OPR for EMEDS, C-STARS, and CCCATT Advanced Course. Contact NGB/SGAX for further guidance. All other UTC formal training will be scheduled through the Base Education Training Manager (BETM).

5.4.1.6.2. AFRC personnel, in collaboration with their unit, will submit an AF Form 101 to their wing training office to receive a Training Line Number (TLN) to attend UTC formal courses. When the AF Form 101 is submitted, the unit will provide HQ AFRC/SGX the name, UTC, AFSC, and alternate training dates the individual can attend training. If no seat in the class is available, AFRC/SGX will provide alternate class dates, as needed. AFRC personnel will comply with the submission, cancellation, and no show guidance stated below.

5.4.2. Category II: Deployment Training – UTC-Specific Training. Expeditionary Medical Support (EMEDS) Course. Personnel assigned to EMEDS UTCs attend training as listed below:

5.4.2.1. UTCs FFDAB, FFEP1, FFEP2, FFEP3, FFEP4, FFEP5, FFEP6, FFF0C, FFHSR, FFMFS, FFPCM, FFPM1, FFPM2, FFPM3, and FFP01 attend the EMEDS Formal Course within six months of initial assignment to the UTC and every 36 months thereafter. (Tier 0: DoDI 1322.24.) An RTOC-sponsored exercise, e.g., Silver Flag, or MRA-approved UTC MET-driven exercise can be substituted for the formal course only after initial training is completed (exceptions must be approved by MRA). EMEDS training requirements are the same for AD and ARC units. Training must be complete prior to entering the deployment vulnerability window. **Exception:** In the case where a member has an opportunity to participate in a sustainment training platform, prior to attendance at the formal/initial course, UTC-specific training credit may be requested through the parent MAJCOM/SGX to the appropriate MRA/SGX for approval. Personnel granted such credit must attend the UTC formal course during their next training cycle.

5.4.2.2. For AD units, EMEDS class submissions will be sent to the ACC scheduler by the MAJCOM POC via the EMEDS Scheduler no later than 90 days prior to class start date. The ACC scheduler will compile and return the master class roster to the MAJCOM POCs NLT 60 days prior to the class start date. MAJCOM POCs will validate their personnel, make changes if required, and return the roster to HQ ACC/SGX (EMEDS Course scheduler) by the suspense date. Cancellations for EMEDS training must be submitted a minimum of 30 days prior to the class start date. If within the 30-day window and no replacement is offered, a request for cancellation should be signed by the MTF commander and submitted to HQ ACC/SGX via e-mail or fax. MAJCOM/SGX or MAJCOM A3O offices will concur/non-concur. Within 14 days prior to class start date, justification for removal/substitution is limited to emergency leave, hospitalization, profile, or early deployment. Cancellation requests are not accepted after class start date and any student with an obligated training line number failing to report to class will require a no-show acknowledgement letter generated by their MTF commander and submitted to HQ ACC/SGX within 7 days.

5.4.3. Category II: Deployment Training – UTC-Specific Training. Patient Decontamination Course. The team chief and NCOIC assigned to UTC FFGLB will attend the Patient Decontamination Course within six months of assignment and every 48 months thereafter. (T-0: DoDI 1322.24) Other FFGLB personnel may attend on a space available basis. Upon completion of the course, the team chief and NCOIC will train the remaining team members, using the MCRP patient decontamination assemblage AS 886A, on a recurring 48 month cycle as well. (T-0: DoDI 1322.24) While the 886A equipment is different from the UTC FFGLC AS 902A equipment, patient decontamination processes are similar and can be practiced using the MCRP team's equipment.

5.4.4. Category II: Deployment Training - UTC- Specific Training. Aeromedical Evacuation and Patient Staging Course (AEPSC). Personnel assigned to UTCs, UTCs FFEPS, FFPPS, FFFPS, and FFHPS will complete the AEPSC, and the associated computer-based training (CBT) within 12 months of assignment. (T-0: DoDI 1322.24) FFEPS and FFPPS personnel will attend AEPSC every 24 months after placement on the UTC. (T-0: DoDI 1322.24) Personnel assigned to all other ERPSS UTCs will, after initial training, attend sustainment training every 48 months by either participation in an RTOC or MRA (AMC/SG) approved exercise or go back to the formal course. Personnel assigned to fixed en-route patient staging (ERPS) facilities will complete AEPSC one time, within 12 months of assignment, unless also assigned to an ERPSS UTC that requires sustainment training as described above. (T-0: DoDI 1322.24) Training must be complete prior to entering the deployment vulnerability window. **Exception:** In the case where a member has an opportunity to participate in a sustainment training platform, prior to attendance at the formal/initial course, UTC-specific training credit may be requested through the parent MAJCOM/SGX to the appropriate MRA/SGX for approval. Personnel granted such credit must attend the UTC formal course during their next training cycle.

5.4.4.1. For AC, AEPSC class submissions will be sent to the AMC scheduler by the MAJCOM POC no later than 90 days prior to class start date. The AMC scheduler will compile and return the master class roster to the MAJCOM POCs no later than 60 days prior to the class start date. MAJCOM POCs will validate their personnel, make changes if required, and return the roster to HQ AMC/SGX (AEPSC Course scheduler) by the



suspense date. Cancellations for AEPSC must be submitted a minimum of 30 days prior to the class start date. If within the 30-day window and no replacement is offered, a request for cancellation should be signed by the MTF commander and submitted to HQ AMC/SGX via e-mail or fax. MAJCOM/SGX or MAJCOM A3O offices will concur/non-concur. Within 14 days prior to class start date, justification for removal/substitution is limited to emergency leave, hospitalization, profile, or early deployment. Cancellation requests are not accepted after class start date and any student with an obligated training line number failing to report to class will require a no-show acknowledgement letter generated by their MTF commander and submitted to HQ AMC/SGX within seven days.

5.4.4.2. For AFRC units, personnel will submit an AF Form 101 through their unit to the wing training office to receive a Training Line Number (TLN) to attend the course. When the AF Form 101 is submitted, the unit will provide HQ AFRC/SGX the name, UTC, AFSC, and alternate training dates the individual can attend training. If no seat in the class is available, AFRC/SGX will provide alternate class dates, as needed. AFRC personnel will comply with the submission, cancellation, and no show guidance stated above.

5.4.4.3. For ANG units, AEPSC will be scheduled by submitting an AEPSC training request, through their Unit Training Manager (UTM), to the Base Education Training Manager (BETM) in-turn will submit it to the NGB/A3 in accordance with current guidance. Primary and secondary class dates should be listed as noted on the request. If alternate dates were requested, NGB will provide alternate class dates to the UTM and/or BETM, as needed, if no seat in the primary or secondary class is available.

5.4.4.4. Passports are required for the FFEPS and FFFPS UTCs (Enabler only), due to their worldwide deployability for short notice military or humanitarian response missions.

5.4.5. Category II: Deployment Training – UTC-Specific Training. Critical Care Air Transport Team (CCATT). UTC-specific training required for personnel assigned to FFCCT includes the CCATT Initial Course, CCATT Advanced Course, and AEPSC, as described below. (T-0: DoDI 1322.24) Personnel assigned to FFQE4 are not required to complete AEPSC, but must attend the CCATT Initial and Advanced courses. (T-0: DoDI 1322.24) Personnel may not be employed or deployed as CCATT members until they have completed the CCATT initial course, AEPSC, and CCATT advanced course. CCATT members must also complete all additional training requirements as outlined in AFTTP 3-42.51, *Critical Care Air Transport Teams*. All members nominated for CCATT duty will undergo a position-specific skill validation process administered by AFEMSI under the authority of the AMC/SG, the CCATT MRA. Personnel must be approved for CCATT duty through the validation process prior to assignment to a CCATT UTC and entry into the CCATT training pipeline. Reference AFTTP 3-42.51 for the validation process. Members will be clinically current to deploy. (T-1)

5.4.5.1. CCATT Initial Course. Personnel assigned to FFCCT or FFQE4 will attend the CCATT initial course at USAFSAM one time only, within 6 months of assignment to the UTC.

5.4.5.2. CCATT Advanced Course. Active duty personnel assigned to FFCCT or FFQE4 will complete the CCATT advanced course at an AMC/SG approved C-STARS platform within 12 months following completion of the CCATT initial course, and every 24 months thereafter. (T-0: DODI 1322.24) ARC CCATT personnel will complete the CCATT advanced course every 48 months, normally beginning in the cycle immediately following the one in which they completed the CCATT initial course. ARC CCATT personnel identified to support a CCATT deployment must have completed the CCATT Advanced Course within 24 months prior to deployment. (T-0: DODI 1322.24) Personnel who do not successfully complete the CCATT Advanced Course will be ineligible to deploy and must be replaced. Sufficient lead time is required to ensure the individual, or a designated replacement if the primary fails the course, completes the training successfully prior to deployment. The waiver authority for the CCATT Advanced Course training for CCATT personnel is AMC/SG. **Note:** Clinical Validation Committee (CVC) approval is required prior to scheduling CCATT training.

5.4.5.3. AEPSC. Active duty personnel assigned to FFCCT will complete initial AEPSC within 12 months, and only after successful completion, of the CCATT initial course. ARC personnel assigned to FFCCT will attend initial AEPSC within 18 months of, and only after successful completion of the CCATT initial course. Waivers for initial AEPSC attendance may be requested in accordance with AFTTP 3-42.51.

5.4.5.4. Operational Support Flier (OSF). All CCATT personnel must complete the requirements for operational support flier (OSF) status in accordance with AFI 11-402, *Aviation and Parachutist Service, Aeronautical Ratings and Badges*, in order to participate in the aerial flight portion of their mission. (T-1) They must maintain currency in OSF requirements as long as they are assigned to CCATT UTCs. Personnel may not be employed or deployed as CCATT members if they are not current in OSF requirements.

5.4.5.4.1. OSF-qualified CCATT personnel must be issued aeronautical orders (AO) through the home station Host Aviation Resource Management (HARM) office prior to participating in aerial flight activities. CCATTs must be issued appropriate flying protective clothing and equipment upon initial UTC assignment and for deployment as defined in AFTTP 3-42.51.

5.4.5.4.2. OSF-qualified CCATT personnel require non-interference AOs, when participating in CCATT training missions.

5.4.5.4.3. Government passports are required for all CCATT personnel. Passport requests should be initiated for CCATTs upon returning to home station after completing the CCATT Initial Course to facilitate expedient processing.

5.4.6. Category II: Deployment Training – Expeditionary/Frozen Blood Course. This training is conducted at the Armed Services Whole Blood Processing Lab (ASWBPL) - West, Travis AFB. Personnel assigned to the Expeditionary/Frozen Blood UTCs FFBD1, FFBD1, FFBD2 and FFBD3 will attend this course within six months of initial assignment to the UTC and every 48 months thereafter. (T-0: DoDI 1322.24)

5.4.7. Category II: Deployment Training – Joint Biological Agent Identification and Diagnostic System (JBAIDS). Personnel assigned to UTC FFBAT attend JBAIDS Training

within six months of initial assignment to the UTC. (T-0: DoDI 1322.24) JBAIDS Training is conducted at the U.S. Army Medical Department Center and School, Fort Sam Houston, TX. Formal JBAIDS Training is a one-time requirement. JBAIDS proficiency/competency testing is required every 12 months. (T-2) Competency training is conducted using the JBAIDS equipment system assigned locally to the MCRP team.

5.4.8. Category II: Deployment Training – Centers for Sustainment of Trauma and Readiness Skills (C-STARS). C-STARS platforms are military-civilian partnerships that provide advanced sustainment training at specific civilian Level-1 trauma centers.

5.4.8.1. C-STARS attendance is required every 24 months for providers, nurses, and clinical technicians as listed on the C-STARS Training Matrix available on the AF Medical Readiness SharePoint Site and must be completed a minimum of 30 days prior to the start of individual's deployment vulnerability period. (T-1)

5.4.8.1.1. C-STARS quotas will be allocated in the following priority order: 1) Tasked deployers, 2) UTC requirements, 3) Consultant/CFM recommended, 4) All others based on space available (e.g. RSVP).

5.4.8.2. C-STARS Waivers and exemptions.

5.4.8.2.1. Waivers to the 24 month attendance requirement must be approved in writing by the specialty consultant and submitted to the individual's MR Office and parent MAJCOM/SGX. (T-1) The MR Office will document the waiver in MRDSS ULTRA and maintain a copy (printed or electronic) of the waiver until the end of the individual's deployment vulnerability window.

5.4.8.2.2. C-STARS exemptions may be granted on a case-by-case basis by the specialty consultant or CFM and will be re-validated every 24 months. Maintain a copy (printed or electronic) of the exemption document for 24 months.

5.4.8.2.3. For individuals who are tasked to deploy, copies of exemptions or waivers will be submitted by the MAJCOM/SGX to the gaining AFFOR/SG.

5.4.8.2.4. Surgeons tasked to deploy should make every attempt to attend the Emergency War Surgery Course (EWSC) prior to deployment, regardless of whether they are required to attend C-STARS. In addition, thoracic (45S3A), cardiac (45S3C), vascular (45S3E), and trauma (45S3K) surgeons practicing in their specialties may be exempted from C-STARS by the consultant, but are required to attend the EWSC prior to deployment.

5.4.8.2.5. C-STARS training is highly encouraged for family practice physicians (44F3) assigned to FFPCM or other standard deployable UTCs. The Family Medicine Consultant may direct specific deploying family practice physicians to attend C-STARS based on a projected deployment location or operational requirement

5.4.8.2.6. Exempted or waived individuals will submit a copy of the documentation to the MR Office for documentation in MRDSS ULTRA.

5.4.8.3. MR offices should consider limited C-STARS class sizes and encourage members with regular trauma, surgical, or resuscitative experience to apply for exemption and appropriately schedule their personnel by staggering them over several

classes. The student application process includes the submission of an extensive credentialing package required by host institutions. Students must meet the institutional deadlines specified in the credentialing package or their attendance will be subject to cancellation. The approval authority for exceptions or extensions to the deadlines is USAFSAM/ETS (AFEMSI).

5.4.8.4. C-STARS training attendance cancellations must be submitted a minimum of 45 days prior to the class start date. (T-2) Units and MAJCOM/SGXs should make every effort to find a replacement locally or within the MAJCOM. If it is within the 45-day window and no replacement student is available, the request for cancellation will be signed by the medical unit commander and submitted through the parent MAJCOM/SGX to USAFSAM/ETS (AFEMSI).

5.4.9. Category II: Deployment Training. TRANSCOM Regulating Command & Control Evacuation System (TRAC2ES). All personnel assigned to UTC FFPME will complete TRAC2ES course upon assignment to the UTC. (T-2) This training is conducted at U.S. TRANSCOM/SG, Scott AFB, IL or completed via Web Based Training.

5.4.10. Category II: Deployment Training – Human Remains Preservation. Human Remains Preservation training is completed by all medical personnel who are tasked to deploy, following Tier 2B Pre-Deployment Training timelines, as described in AFI 36-2201. (T-0: National Defense Authorization Act, section 567) This federally mandated training (reference the 2007 National Defense Authorization Act, section 567) is designed to provide an understanding of human remains preservation requirements, procedures for retrieval and processing of remains; cultural implications; and medical planning considerations including technician safety. Human Remains Preservation training can be accessed on MED+LEARN, through the Advanced Distributed Learning Service (ADLS) gateway.

## **5.5. Category III: Unit Training.**

5.5.1. Category III: Unit Training – MCRP Team Training. MCRP team training conducted at the unit is designed to maximize team member interaction and role reinforcement and includes leadership elements. MCRP team training is required for all members assigned to an MCRP team and will be tailored to the mission and capabilities identified in the team's annex. All MCRP team members must also maintain proficiency on assigned equipment. (T-1) The team chief will identify and incorporate specific training requirements into team lesson plans and training schedule. These specific training requirements will include annual hands-on refresher training.

5.5.1.1. HAZMAT training requirements established by AFI 10-2501, *Air Force Emergency Management (EM) Program Planning and Operations*, and Occupational Safety and Health Administration (OSHA) Best Practices are required for First Receivers/Responders, as applicable to each MCRP team, and the didactic portion is available on Med+Learn and required annually unless otherwise noted. This HAZMAT training is implemented in the AFMS as follows:

5.5.1.1.1. Enhanced First Responder Awareness: This training is the HAZMAT First Responder Awareness course that is designed specifically for the Field Response Team and ambulance drivers.

5.5.1.1.2. First Receiver Awareness: This training is the HAZMAT First Responder Awareness course modified for medical first receivers. This training is required for all personnel who work in the medical facility in support of patient care and may have contact with contaminated victims, their belongings, equipment, or waste. This includes administrative and ancillary support personnel who work in duty sections that may be first to identify a contaminated patient, such as a door greeter or receptionist. The MTF commander may use discretion in deciding if personnel who aren't likely to come in contact with patients, require this training. BE team personnel are not required to accomplish this training.

5.5.1.1.3. Combined First Receiver Awareness and Operations Training: This training is the combined HAZMAT First Receiver Awareness and Operations course. This training is required for all personnel who have a designated role in or around the decontamination zone outside the medical facility. Members need to successfully complete both the didactic and hands-on training with the PPE to meet the initial training requirements. Annual requirements can be met with a demonstration of competencies through participation in an exercise, tactical drill or real-world response.

5.5.1.1.4. HAZMAT First Responder Operations: All Bioenvironmental Engineering team personnel require HAZMAT Operations level training and DoD certification.

5.5.1.2. Specialized MCRP Team Training: Some MCRP teams have unique training to support their mission requirements. These teams and their unique training are provided below.

5.5.1.2.1. Patient Decontamination Team: The Patient Decontamination Team Chief and NCOIC will attend and successfully complete the Patient Decontamination Course (L3ORP4XXX 00DA) one-time only, within six months of assignment. (T-1) Within 90-days of completion of the course, the team chief and NCOIC will train the remaining team members using the MCRP patient decontamination assemblage, AS 886A, every 12 months. (T-1) **Note:** For team chiefs and NCOICs stationed at remote locations, attendance of the course is not required as long as they are trained locally by an individual who has attended the formal course. This training must occur within 30 days of assignment. If no formally trained individual is available, the team chief and NCOIC must attend the formal course. Training can be also accomplished through other courses, as approved by HQ ACC/SGX.

5.5.1.2.2. Laboratory Biological Detection Team (LBDT): Laboratory teams maintaining JBAIDS, M1M, or both capabilities will have at least 2 members of the team current in the requirements for each platform maintained. (T-1) Requirements for each platform include both completion of the respective JBAIDS and M1M formal courses and currency in the corresponding proficiency/competency program. Formal course attendance is a one-time requirement. Proficiency testing must be accomplished every 12 months by each member. **Note:** testing occurs 3 times each year.

5.5.1.3. Respiratory Protection: All MCRP teams required to utilize respiratory protection will comply with the requirements of AFOSH Std. 48-137, *Respiratory Protection Program*, as applicable. (T-0: 29 CFR 1910.134)

5.5.1.4. Air Force Emergency Management Program Course (AFEMPC): All MCRP team members will complete the AFEMPC every three years. (T-2)

## **5.6. Training Equivalency.**

5.6.1. Exercises. Sustainment training credit may be granted for locally-sponsored UTC Mission Essential Task-driven exercises with prior MRA approval. Local exercises must use UTC equipment packages to qualify for sustainment credit. A list of exercises the MRA has approved for sustainment credit may be found on the applicable MRA's SharePoint Site. An after action report defining personnel and equipment UTCs participating in the exercise and a list of participants must be sent to the approving MRA. For exercises not listed, requests for credit should be submitted to the appropriate MRA no later than 60 days prior to the start date. Once an exercise is approved for sustainment training credit by the MRA, training participation will be verified by the MR office and updated in MRDSS ULTRA using the exercise end date as the training completion date.

### **5.6.2. Deployments.**

5.6.2.1. Members may request UTC sustainment training credit for participation in real world operations and/or deployments. Members who have deployed and performed duties consistent with their assigned UTC, utilizing the UTC's assigned war reserve materiel (WRM) equipment assemblages in an expeditionary (Bare Base) environment may request UTC sustainment training credit. Requests will be forwarded to the appropriate MRA for approval. If approved, the deployment return date will be used as the training completion date.

5.6.2.2. Members may request GRL equivalency credit for real world operations and/or deployments. Members who have deployed 14 days or more to an austere environment in a 48 month period and have performed duties consistent with deployment as GRL or Preventive Medicine Team (FFPM1/2) may request credit for specific training requirements. Requests will be forwarded to HQ AMC/SGX who will coordinate approval/disapproval with HQ AMC/SGP. If approved, the deployment return date will be used as the training completion date.

## Chapter 6

### MEDICAL UNIT EXERCISES

**6.1. General.** This chapter provides guidance on base-level exercise planning roles and responsibilities, exercise types, requirements, and documentation. Additional information is provided in the AF Medical Readiness Guide.

**6.2. Special Exercise Considerations.**

6.2.1. LS and LSISS MTFs will work with their wing/base/installation IG (or equivalent) to determine the best way to conduct exercises required by other AFIs or directives. MTFs will combine their exercises with sister service or wing/base/installation exercises to the greatest extent possible. Exercise scenarios must be developed collaboratively to test medical response capabilities as they would realistically be employed. In addition, LS and LSISS MTFs will conduct each of the following recall types annually: emergency/disaster response teams, UTCs, deployment support team(s), and one unit-wide recall. The unit-wide recall may alternate between telephonic only and report-to-duty each year and may be combined with other exercises, as appropriate. (T-2)

6.2.2. LSISS MTFs may also be required to participate in host unit/service exercises.

6.2.3. Deployed MTFs should participate in the host wing/base/installation's exercise program, as mission requirements permit, especially major accident response. Deployed MTFs are not expected to plan or conduct large-scale exercises on their own; however, deployed MTFs must conduct a unit-wide recall, or personnel accountability exercise, every three months.

**6.3. Required Exercises.** Exercise requirements are governed by AFI 90-201 (see Table 5.1 for exercise frequency and governing directive), this Instruction and other directives. Non-medical exercise requirements may be met by participating in wing/installation exercises. If the wing/installation does not accomplish all non-medical exercises, the medical unit is not expected to accomplish them independently. However, if wing exercises that are conducted do not adequately test the medical unit's capabilities (for example, the exercise stops at the entrance to the medical facility), units will develop internal scenarios to supplement or extend the exercise. The following medical-specific exercises are mandated by this Instruction:

6.3.1. Recalls. Recall exercises demonstrate the unit's ability to return to duty in response to a contingency situation. Acceptable response standards are generally established by the wing. If no wing standard exists, the MRC must establish the standard and include it in Annex A of the MCRP. Conduct each of the following recall types at least once annually: MCRP Teams, UTCs, deployment support teams, and one unit-wide recall. The unit-wide recall may alternate between telephonic only and report-to-duty each year and may be combined with other exercises, as appropriate. (T-2)

6.3.2. Medical Emergency Response Exercises. Units that publish MCRPs are required to exercise each annex annually, in conjunction with wing/installation exercises or conducted separately at the unit level. (T-0: The Joint Commission (TJC) Standards) At the commander's discretion, annexes may be exercised together, as part of a comprehensive exercise, as functionally appropriate to support realistic scenarios and response. Units that

do not publish MCRPs, but provide input to the IEMP 10-2 or sister service equivalent IEM plans, must also exercise this capability annually. Emergency response exercises will include an influx from outside the organization of volunteer or simulated casualties. Enough casualties should be used to adequately test the organization's resources and reactions under stress.

**6.4. Exercise Credit.** Medical units may take exercise credit for real world response of similar scope and magnitude to the exercise intent of plan activation and modification of the normal use of services, equipment, staff, and normal patient management procedures. For example, a response to a bus accident with multiple casualties utilizing numerous MCRP teams may satisfy a major accident exercise requirement. The same post-event procedures, such as a post-incident hot wash and PIES, as well as MRC/EMC review must occur for real world incidents. Credit may be taken only when objectives are met for the specific exercise type or subsequent corrective action is successful.

**6.5. Post-Incident/Exercise Summary (PIES).** Medical units will generate a PIES for each exercise they participate in, regardless of which agency conducted the exercise. The PIES is compiled by the MR office within 30 days of the incident or event, with input from participating team chiefs, observers and evaluators. (T-0: The Joint Commission (TJC) Standards) PIES document the unit's participation in an actual incident or exercise as well as individual participation for appointed positions that require regular exercise participation. It describes the scenario, exercise objectives, and whether or not they were met and addresses the effectiveness of associated MCRP annexes and team checklists.

6.5.1. PIES will include the following items, at a minimum:

6.5.1.1. Incident/Exercise Overview. Include the date(s) and location(s) as well as the number and types of casualties, type of incident/exercise, and a list of participating teams, organizations, and key individuals, as applicable.

6.5.1.2. Exercise Objectives. List objectives established for the exercise.

6.5.1.3. Exercise Results/Achievement of Objectives. This section should address how each participating MCRP team's involvement contributed to the achievement of the defined exercise objectives. Include a list of any Defense Readiness Reporting System (DRRS) Mission Essential Tasks (METs) tested as part of the exercise.

6.5.1.4. Findings and Observations. Include both in-house items as well as medical unit items identified at the installation level.

6.5.1.5. Recommended Changes to Checklists and Plans. Identify required changes or updates to the MCRP or IEMP (or equivalent for LSISS MTFs) and supporting checklists. An OPR and suspense for completion will be determined by the MRC/EMC and must be documented in the minutes.

6.5.1.6. Exercise Requirements Fulfilled. List the exercise requirements met by the event. This is particularly important when different exercise types are combined.

6.5.2. PIES will be reviewed by the MRC/EMC and attached to the meeting minutes. Identified findings, observations and areas of concern will be discussed, identified as open items, assigned OPRs, and tracked through the MRC/EMC until resolved.



6.5.3. A sample PIES can be found in the AFI 41-106 Toolbox, located on the AF Medical Readiness SharePoint Site.

## Chapter 7

### MEDICAL READINESS REPORTING

**7.1. Operational Readiness Reports.** Operational readiness reports provide higher headquarters and other interested organizations, up to and including the Office of the Secretary of Defense and National Command Authority, necessary information to make critical decisions with regard to deployments, manpower, and resource requirements. The first three reporting systems described below are populated and updated at the unit level each month, giving commanders the opportunity to assess and report their unit capabilities. The remaining reporting processes are accomplished as needed to relay vital information to higher headquarters before, during or after a deployment or major event, as directed in this Instruction and referenced governing directives.

7.1.1. Global Status of Resources and Training System (GSORTS). GSORTS, also known simply as SORTS, is a JCS owned system used to measure and report the status of a unit's resources and training required to undertake the full scope of its mission.

7.1.1.1. For SORTS training calculations, medical units will report only on formal UTC course attendance and associated sustainment training, as listed in Table 7.1 of this Instruction, using the TRSA1 field for the lowest training platform percentage, as provided by MRDSS ULTRA. (T-0: DoDI 7730.66, CJCSI 3401.02B, AFD 10-2, CJCSM 3150.01, CJCSI 3401.02) All other readiness training, including MCRP team training, will be considered in the unit's DRRS ESORTS assessments, as described in paragraph 7.1.2. below. **Note:** Medical units do not report equipment condition (R-levels) in SORTS.

7.1.1.2. Units with fragmented (shared/split) UTCs will report only on their own portion(s) of the UTC in SORTS.

7.1.1.3. Overall guidance for SORTS reporting is provided in AFI 10- 201.

7.1.2. Defense Readiness Reporting System (DRRS) Enhanced Status of Resources and Training System (ESORTS). DRRS ESORTS focuses on the full scope of the unit's core mission capabilities assessed against mission essential tasks (METs), which are informed by SORTS resource ratings and ART readiness assessments. For Air Force medical units this includes, but is not limited to, all expeditionary or deployable missions (UTCs), as well as all in-place/generation missions, such as support for installation deployment processing, medical emergency response, fixed ERPS facilities, etc. Utilize the unit's Medical Resource Letter (MRL) and the medical UTC-MET list provided in the Readiness Reporting-DRRS folder on the AF Medical Readiness SharePoint Site to determine which METs to assess. Medical unit commanders will assess unit mission capabilities in accordance with AFI 10-252, and the following: (T-0: DoDI 7730.66, CJCSI 3401.02B, AFD 10-2, CJCSM 3150.01, CJCSI 3401.02)

7.1.2.1.1. For deployment missions, consider the deployability, availability, and training of personnel assigned to applicable UTCs, and critical percentages for assigned contingency materiel. For assemblages that do not have critical items, use the readiness percentage. Contingency materiel maintained for other units will be assessed by the "owning/using" units, rather than the "host/maintaining" units.

- 7.1.2.1.2. Reporting medical units will assess their in-place/generation/homeland response missions using AFOP 4.4.3.6; refer to the MCRP (IEMP 10-2 or equivalent IEM plan for LS and LSISS MTFs) to determine which performance measures apply. Consider all assigned unit personnel, to include military members, civilians, and contractors, and their required training (e.g. MCRP team training), when assessing mission capability. Consult available resources such as the MRC, EMC, MCRP team chiefs, as well as PIES and inspection results to facilitate the mission assessment.
- 7.1.2.1.3. For units supporting Named Operations or Top Priority (or Level IV) plans, assess the unit's capabilities using the AFMS Core METL, deleting METs and performance measures the unit is not specifically tasked to provide in support of those operations or plans.
- 7.1.2.1.4. Units with more than one "copy" of a UTC will assess the mission as a whole. For example, Constant Deployer Model (CDM) sites with multiple copies of FFEP2 will assess one EMEDS command and control, administration, medical information systems and medical logistics support (FFEP2) mission capability.
- 7.1.2.1.5. For units with fragmented (shared/split) UTCs, the parent/supported unit assesses the fragmented mission capability as a whole in DRRS. Child/supporting units (those providing manpower to another unit's UTCs) will **not** assess their portion(s) of that capability in DRRS.
- 7.1.2.1.6. If SORTS ratings do not align with DRRS ESORTS assessment levels (e.g. SORTS is C-2 or C-3 and DRRS is Y) provide a unit mission assessment comment explaining the different ratings and rationale in layman's terms. Acceptable DRRS unit mission assessment comments might address SORTS training shortfalls as trainable just-in-time should the unit be required to execute the mission, or a shortage of contingency materiel that is obtainable through local purchase or other logistics channels on a contingency basis.
- 7.1.2.2. Once the AFMS Core METL template has been copied to the unit's DRRS ESORTS, non-applicable METs and performance measures may be deleted after obtaining MAJCOM FAM approval. Update the unit's core METL in DRRS ESORTS anytime the unit's MRL and/or mission changes only by copying applicable METs from the AFMS Core METL. (T-0: DoDI 7730.66, CJCSI 3401.02B, AFD 10-2, CJCSM 3150.01, CJCSI 3401.02) Units will make no other alterations or modifications to the AFMS Core METL within DRRS, but may submit recommendations for updates or changes to the AFMS Core METL to the parent MAJCOM FAM.
- 7.1.2.3. Reference AFI 10-252, *Defense Readiness Reporting System (DRRS)*, for additional guidance.
- 7.1.3. AEF Reporting Tool (ART). ART supplements SORTS data by providing commander assessed ratings for each individual assigned UTC, versus the unit as a whole. It provides a picture of a specific UTC's ability to perform its mission as defined in the UTC MISCAP.
- 7.1.3.1. ART uses the same measured resource areas as SORTS, but enables commanders to report the ability of an individual UTC to perform its mission at the time of the assessment.

7.1.3.2. Medical units with fragmented (shared/split) UTCs will provide an assessment of their own portion(s) of the UTC in ART. (T-0: DoDI 7730.66, CJCSI 3401.02B, AFD 10-2, CJCSM 3150.01, CJCSI 3401.02)

7.1.3.3. Overall guidance on preparing and submitting ART reports is provided in AFI 10-244, *Reporting Status of Aerospace Expeditionary Forces*.

**7.2. Reportable Medical Readiness Training.** Although individual training items listed in Table 7.1 may be applicable to a broader range of UTCs or personnel, they are only reportable for personnel assigned to the UTCs listed. For SORTS T-level calculations, units will report only the lowest percentage of all the applicable training platforms listed in Table 7.1. in the TRSA1 field, using the reportable statistics report in MRDSS ULTRA.

**Table 7.1. Medical Reportable Training (AD & ARC).**

Training Platform	Reportable for
CCATT Initial	All personnel assigned to the following UTCs: FFCCT, and FFQE4.
CCATT Advanced	All personnel assigned to the following UTCs: FFCCT, and FFQE4.
AEPSC	All personnel assigned to the following UTCs: FFEPS, FFPPS, FFFPS, FFHPS, FFCCT
Patient Decontamination	Only the team chief and NCOIC for the FFGLB UTC.
EMEDS	All personnel assigned to the following UTCs: FFDAB, FFMFS, FFEP1, FFEP2, FFEP3, FFEP4, FFEP5, FFEP6, FFF0C, FFPM1, FFPM2, FFPM3, FFPCM, FFHSR and FFP01.
Expeditionary/Frozen Blood	All personnel assigned to the following UTCs: FFBP1, FFBP2, FFBP3 and FFBD1.
C-STARS	All personnel listed on the C-STARS Training Matrix

**7.3. Readiness Reports for Deployed MTFs.** Deployed MTFs should follow Component Numbered Air Force (C-NAF) instructions for submitting updates on operational readiness status, resource availability, and patient care capabilities during contingency operations. Reports will be tailored based on the operational environment and submitted as directed to support critical information flow to higher headquarters.

**7.4. Medical Input to the Wing/Installation Operational Reports.** In-garrison AF medical units influenced by unusual occurrences (e.g., natural disasters, CBRN incidents, major accident response, or other emergencies) will submit input to installation reports, such as Commander's Situation Report (SITREP) and Air Force Operational Reports (AF OPREP-3), to provide critical updates on unit operating status to HHQ, as appropriate. Reports are submitted in accordance with AFI 10-206, *Operational Reporting*. In addition, whenever medical input to a SITREP or OPREP-3 is submitted, send a notification copy via e-mail to the unit's parent MAJCOM/SGX. For medical logistics issues, include a courtesy copy to the Air Force Medical Logistics Operations Center.

7.4.1. Disease/Public Health Emergencies. A disease/public health emergency is defined as: an occurrence or imminent threat of an illness or health condition, caused by biological warfare or terrorism, epidemic or pandemic disease that poses a substantial risk of generating a significant number of human casualties; a medical situation involving a marked increase of disease among AF personnel, or any impending significant disease incident which has the potential to negatively impact mission accomplishment (see OPREP-3B, Rule 13A).

7.4.2. Pandemic Events. Pandemic events reported include: initial confirmed novel pandemic disease case within a command (e.g. installation) or military medical treatment facility (MTF); initial confirmed cluster (2 - 5 cases) suggestive of novel pandemic disease for the period covered by the report; significant mission impact (actual) resulting from pandemic disease outbreak; pandemic disease causing an adverse impact to allocated Defense Support to Civil Authorities (DSCA) forces or to anticipated DSCA missions; other pandemic disease related incidents of significant interest as determined by the reporting organization; or very seriously ill/death(s) due to pandemic involving active duty personnel, civilians, or dependents (see OPREP-3B, Rule 13B).

7.4.3. Significant MTF Events. Significant MTF events include: a natural disaster or other emergency (e.g., tornado, fire, terrorist attack, civil disturbance, etc.) that affects the medical unit's normal operations, capabilities, or otherwise impairs the unit's ability to carry out its mission. Inputs are submitted to provide status updates on completed actions under a previously declared stage of alert or emergency, as directed by higher headquarters or by actions required in response to a natural disaster or other emergency on the installation, where such response impairs the medical unit's mission capability. Significant MTF event submissions are processed through the installation commander as HHQ AF Interest Level items, in accordance with the AF OPREP-3 Matrix (see OPREP-3B, Rule 3A or Rule 3E).

THOMAS W. TRAVIS  
Lieutenant General, USAF, MC, CFS  
Surgeon General

**Attachment 1****GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION*****References***

DODD 1322.18, *Military Training*, January 13, 2009

DODD 3020.26, *Department of Defense Continuity Programs*, January 9, 2009

DODD 3025.18, *Defense Support of Civil Authorities*, December 29, 2010

DODD 6000.12E, *Health Service Operations and Readiness*, January 6, 2011

DODD 6010.22, *National Disaster Medical System*, January 21, 2003

DODD 6490.02E, *Comprehensive Health Surveillance*, February 8, 2012

DODI 1300.21, *Code of Conduct (CoC) Training and Education*, January 8, 2001

DODI 1322.24, *Medical Readiness Training*, October 6, 2011

DODI 2310.08E, *Medical Program Support for Detainee Operations*, June 6, 2006

DODI 3000.5, *Stability Operations*, September 16, 2009

DODI 3020.52, *DoD Installation Chemical, Biological, Radiological, Nuclear, and High-Yield Explosive (CBRNE) Preparedness Standards*

DODI 6000.11, *Patient Movement*, May 4, 2012

DODI 6000.16, *Military Health Support for Stability Operations*, May 17, 2010

DODI 6055.06, *DoD Fire and Emergency Services (F&ES) Program*, December 21, 2006

DODI 6055.17, *DoD Installation Emergency Management Program*, January 13, 2009

DODI 6200.03, *Public Health Emergency Management within the Department of Defense*, March 5, 2010

DODI 6490.03, *Deployment Health*, August 11, 2006

DODI 6490.5, *Combat Stress Control Programs*, November 22, 2011

CJCSI 3150.25E, *Joint Lessons Learned Program*, April 20, 2012

CJCSI 3500.01G, *Joint Training Policy and Guidance for the Armed Forces of the United States*, March 15, 2012

CJCSN 3500.01, *2013-2016 Chairman's Joint Training Guidance*, October 9, 2012

CJCSM 3500.03D, *Joint Training Manual for the Armed Forces of the United States*, August 15, 2012

JP 4-02, *Health Service Support*, July 26, 2012

AFDD 4-02, *Health Services*, June 21, 2012

AFI 10-201, *Status of Resources and Training System*, April 19, 2013

AFI 10-206, *Operational Reporting*, September 6, 2011

AFI 10-208, *Continuity of Operations (COOP) Program*, December 15, 2011

AFI 10-244, *Reporting Status of Aerospace Expeditionary Forces*, June 15, 2012

AFI 10-301, *Responsibilities of Air Reserve Component (ARC) Forces*, August 16, 2006

AFI 10-401, *Air Force Operations Planning and Execution*, December 7, 2006

AFI 10-403, *Deployment Planning and Execution*, September 20, 2012

AFI 10-2501, *Air Force Emergency Management (EM) Program Planning and Operations*, January 24, 2007

AFI 10-2603, *Emergency Health Powers on Air Force Installations*, October 13, 2010

AFI 10-2604, *Disease Containment Planning Guidance*, September 3, 2010

AFI 11-402, *Aviation and Parachutist Service, Aeronautical Ratings and Badges*, December 13, 2012

AFI 25-201, *Support Agreements Procedures*, May 1, 2005

AFI 33-360, *Publications and Forms Management*, February 7, 2013

AFI 36-2201, *Air Force Training Program*, September 15, 2010

AFI 41-120, *Medical Resource Operations*, October 18, 2001

AFI 41-209, *Medical Logistics Support*, August 13, 2013

AFI 44-102, *Medical Care Management*, January 20, 2012

AFI 44-153, *Traumatic Stress Response*, August 29, 2011

AFI 44-162, *International Health Specialist (IHS) Program*, July 7, 2011

AFI 48-105, *Surveillance, Prevention, and Control of Diseases and Conditions of Public Health or Military Significance*, March 1, 2005

AFPAM 10-100, *Airman's Manual*, March 1, 2009

AFPD 10-25, *Emergency Management*, September 26, 2007

AFPD 41-1, *Health Care Programs and Resources*, April 15, 1994

AFTTP 3-42.1, *Health Service Support Command and Control in Expeditionary Operations*, May 14, 2004

AFTTP 3-42.32, *Home Station Medical Response to Chemical, Biological, Radiological and Nuclear (CBRN) Events*, August 13, 2009

AFTTP 3-42.51, *Critical Care Air Transport Teams*, September 7, 2006

**References maintained on the AF Medical Readiness SharePoint Site:**  
(<https://cs3.eis.af.mil/sites/OO-SG-AF-83/default.aspx>)

AFMS Mission Briefing

CSTARS Training Matrix

Deployed MTF Assessment Checklist

Medical Readiness Training Equivalency Matrix

MRC Presentation Template

PIES Template

Unit Mission Briefing Template

Weapons and Munitions Forecasting Matrix

***Adopted Forms***

AF Form 101, *Reserve Requirements for School Tours of Active Duty for Training*

AF Form 1098, *Special Task Certification and Recurring Training*

AF IMT 4005, *Individual Deployment Requirements*

AF Form 847, *Recommendation for Change of Publication*

DD Form 1934, *Geneva Conventions Identification Card.*

***Abbreviations and Acronyms***

**AAR**—After-Action Report

**ACC**—Air Combat Command

**ACLS**—Advanced Cardiac Life Support

**AD**—Active Duty

**ADLS**—Advanced Distributed Learning Service

**AE**—Aeromedical Evacuation

**AEF**—Air and Space Expeditionary Force

**AEPSC**—Aeromedical Evacuation and Patient Staging Course

**AETC**—Air Education and Training Command

**AF**—JLLIS – Air Force-Joint Lessons Learned Information System

**AFCENT**—Air Forces Central

**AFDF**—Air Force Deployment Folder

**AFEMSI**—Air Force Expeditionary Medical Skills Institute

**AFIA**—Air Force Inspection Agency

**AFMAN**—Air Force Manual

**AFMOA**—Air Force Medical Operations Agency

**AFMSA**—Air Force Medical Support Agency

**AFMS**—Air Force Medical Service

**AFPC**—Air Force Personnel Center

**AFRC**—Air Force Reserve Command



**AFSC**—Air Force Specialty Code  
**AFTH**—Air Force Theater Hospital  
**AFTR**—Air Force Training Record  
**AFTTP**—Air Force Tactics, Techniques and Procedures  
**AFUTL**—Air Force Universal Task List  
**AOR**—Area of Responsibility  
**ARC**—Air Reserve Component (includes Air National Guard and Air Force Reserve Command)  
**ART**—AEF Reporting Tool; also Air Reserve Technician  
**AS**—Allowance Standard  
**AT**—Annual Training; also Annual Tour (ARC)  
**ATLS**—Advanced Trauma Life Support  
**BEE**—Bioenvironmental Engineer  
**BEMRT**—Basic Expeditionary Medical Readiness Training  
**BETM**—Base Education Training Manager  
**BP**—Building Partnerships  
**BPC**—Building Partnership Capacity  
**BW**—Biological Warfare  
**C2**—Command and Control  
**C4I**—Command, Control, Communications, Computers and Information  
**CAFSC**—Control AFSC  
**CASF**—Contingency Aeromedical Staging Facility  
**CBD**—Consultant Balanced Deployments  
**CBRN**—Chemical, Biological, Radiological and Nuclear  
**CBRNE**—Chemical, Biological, Radiological, Nuclear, and High-Yield Explosive  
**CBT**—Computer-based Training  
**CCB**—Configuration Control Board  
**CCIP**—Wing Commander's Inspection Program Management Internal Control Toolset (MICT)  
**CCATT**—Critical Care Air Transport Team  
**CCDR**—Combatant Commander  
**CCMRF**—CBRN Consequence Management Response Force  
**CDM**—Constant Deployer Model  
**CE**—Civil Engineering

**CERFP**—ANG Chemical Biological Radiological Nuclear and High Yield Explosive Enhanced Response Force Packages

**CFM**—Career Field Manager

**CONOPS**—Concept of Operations

**COOP**—Continuity of Operations

**COT**—Commissioned Officer Training

**CPM**—Contingency Preventive Medicine

**CRG**—Contingency Response Group

**CSC**—Combat Stress Control

**CSDC**—Consolidated Storage and Deployment Center

**CSS**—Commander's Support Staff; also Commander's Senior Staff; also Central Sterile Supply

**C-STARS**—Centers for Sustainment of Trauma and Readiness Skills

**DAFSC**—Duty Air Force Specialty Code

**DAV**—Deployment Availability

**DHP**—Defense Health Program

**DMLSS**—Defense Medical Logistics Standards Support

**DOC**—Designed Operational Capability

**DRRS**—Defense Readiness Reporting System

**DRU**—Direct Reporting Unit

**DSCA**—Defense Support to Civil Authorities

**E&T**—Education and Training

**E&TC**—Education and Training Committee

**ECD**—Estimated Completion Date

**EM**—Emergency Management

**EMC**—Executive Management Committee

**EMEDS**—Expeditionary Medical Support

**EMRC**—Expeditionary Medical Readiness Course

**EOC**—Emergency Operations Center

**EPRC**—Emergency Preparedness and Response Course

**ERPSS**—En-route Patient Staging System

**ESORTS**—Enhanced Status of Resources and Training System

**FAM**—Functional Area Manager

**FCC**—Federal Coordinating Center

**FOA**—Forward Operating Area; also Field Operating Agency  
**FOUO**—For Official Use Only  
**GSORTS**—Global Status of Readiness and Training System  
**HA/DR**—Humanitarian Assistance & Disaster Relief  
**HAF**—Headquarters Air Force  
**HARM**—Host Aviation Resource Management  
**HAZMAT**—Hazardous Material  
**HRF**—Homeland Response Force  
**HSMR**—Home Station Medical Response  
**HSPD**—Homeland Security Presidential Directive  
**HSW**—Human Systems Wing  
**IDMT**—Independent Duty Medical Technician  
**IDP**—Installation Deployment Plan  
**IEM**—Installation Emergency Management  
**IEMP**—Installation Emergency Management Plan  
**IF**—Institutional Force  
**IHS**—International Health Specialist  
**IMA**—Individual Mobilization Augmentee  
**IM/IT**—Information Management/Information Technology  
**IMR**—Immediate Medical Response; also Individual Medical Readiness  
**IPR**—Individual Personnel Readiness  
**IS**—Information Systems  
**ISDRT**—Information Services Disaster Response Team  
**JBAIDS**—Joint Biological Agent Identification Diagnostic System  
**JCS**—Joint Chiefs of Staff  
**JIT**—Just-In-Time  
**JLLIS**—Joint Lessons Learned Information System  
**JTF**—Joint Task Force  
**Kx**—Knowledge Exchange  
**LAF**—Line of the Air Force  
**LBDT**—Laboratory Biological Detection Team  
**LOAC**—Law of Armed Conflict

**LRN**—Laboratory Response Network

**LS MTF**—Limited Scope Medical Treatment Facility

**LSISS MTF**—Limited Scope with Inter-Service Support Medical Treatment Facility

**MAA**—Mutual Aid Agreement

**MAF**—Mobility Air Forces

**MAJCOM**—Major Command

**MASF**—Mobile Aeromedical Staging Facility

**MCC**—Medical Control Center

**MC**—CBRN - Medical Counter-CBRN

**MCRP**—Medical Contingency Response Plan

**MEFPAK**—Manpower and Equipment Force Packaging System

**MEM**—Medical Emergency Manager

**MET**—Mission Essential Task

**METL**—Mission Essential Task List

**MICT**—Management Internal Control Toolset

**MISCAP**—Mission Capability

**MOA**—Memorandum of Agreement

**MOU**—Memorandum of Understanding

**MR**—Medical Readiness

**MRA**—MEFPAK Responsible Agency

**MRC**—Medical Readiness Committee

**MRDSS**—Medical Readiness Decision Support System

**MRDSS ULTRA**—Medical Readiness Decision Support System Unit-level Tracking and Reporting Application

**MRL**—Medical Resource Letter

**MRM**—Medical Readiness Manager

**MRMC**—Medical Readiness Management Course

**MRNCO**—Medical Readiness Noncommissioned Officer

**MRO**—Medical Readiness Officer

**MRT**—Medical Readiness Training

**MTF**—Medical Treatment Facility

**NAF**—Numbered Air Force

**NBC**—Nuclear, Biological, Chemical

**NCMI**—National Center for Medical Intelligence  
**NDMS**—National Disaster Medical System  
**NGB**—National Guard Bureau  
**NREMT**—National Registry of Emergency Medical Technicians  
**O&M**—Operations and Maintenance  
**OCONUS**—Overseas Continental United States  
**OJT**—On-the-job Training  
**OPLAN**—Operation Plan  
**OPR**—Office of Primary Responsibility  
**OTS**—Officers Training School  
**PAFSC**—Primary Air Force Specialty Code  
**PAR**—Population at Risk  
**PEM**—Program Element Manager (Monitor)  
**PHEO**—Public Health Emergency Officer  
**PHNCO**—Public Health Non-commissioned Officer  
**PHO**—Public Health Officer  
**PHTLS**—Prehospital Trauma Life Support  
**PIES**—Post-Incident/Exercise Summary  
**PMI**—Patient Movement Item  
**POC**—Point of Contact  
**POM**—Program Objective Memorandum  
**PPBES**—Programming, Planning and Budgeting Execution System  
**PPE**—Personal Protective Equipment  
**PRC**—Primary Receiving Center  
**PRT**—Patient Reception Team  
**RCOT**—Reserve Commissioned Officer Training  
**RSVP**—Readiness Skills Verification Program  
**RTOC**—Readiness Training Oversight Committee  
**SEI**—Special Experience Identifier  
**SFS**—Security Forces Squadron  
**SME**—Squadron Medical Element; also Subject Matter Expert  
**SOF**—Special Operations Forces

**SORTS**—Status of Resources and Training System

**SSC**—Secondary Support Center

**STARS**—P – Sustainment of Trauma and Resuscitation Skills Program

**TAA**—Training Affiliation Agreements

**TDY**—Temporary Duty

**TLN**—Training Line Number

**TPFDD**—Time-Phased Force Deployment Data

**TR**—Traditional Reservists

**TRG**—Training Group

**TTP**—Tactics, Techniques and Procedures

**TTX**—Tabletop Exercise

**UDM**—Unit Deployment Manager

**ULN**—Unit Line Number

**ULTRA**—Unit- Level Training and Reporting Application

**UMD**—Unit Manning Document

**USAFSAM**—US Air Force School of Aerospace Medicine

**UTA**—UTC Availability (replaced the AFWUS); also Unit Training Assembly

**UTC**—Unit Type Code

**VA**—Veterans Administration

**WMD**—Weapons of Mass Destruction

**WMP**—War and Mobilization Plan

**WRM**—War Reserve Materiel

### *Terms*

**Aeromedical Evacuation (AE)**—AE provides timesensitive en route care of regulated casualties to and between medical treatment facilities using organic and/or contracted aircraft with medical aircrew trained explicitly for that mission. AE forces can operate as far forward as aircraft are able to conduct air operations, across the full range of military operations, and in all operating environments. Specialty medical teams may be assigned to work with the AE aircrew to support patients requiring more intensive en route care.

**Annual Training**—A training period related to the calendar year. Training required on an annual basis must be accomplished every calendar year, but not exactly every twelve months, e.g., an individual who attends an annual training event on 1 Jan 2009 is current until 31 Dec 2010.

**Community Recovery**—The process of assessing the effects of an Incident of National Significance, defining resources, and developing and implementing a course of action to restore and revitalize the socioeconomic and physical structure of a community.

**Core requirements**—Those essential individual training requirements needed to accomplish the AFMS mission.

**Critical Infrastructure**—Systems and assets, whether physical or virtual, so vital to the US that the incapacity or destruction of such systems and assets would have a debilitating impact on security, national economic security, national public health or safety, or any combination of those matters.

**Defense Support of Civil Authorities (DSCA)**—Refers to DOD support, including Federal military forces, DOD civilians and DOD contractor personnel, and DOD agencies and components, for domestic emergencies, and for designated law enforcement and other activities.

**Disease Prevention**—Encompasses the anticipation, prediction, identification, prevention, and control of preventable diseases, illnesses, and injuries caused by exposure to biological, chemical, physical or psychological threats or stressors found at home station and during deployments.

**Emergency Operations Center (EOC)**—The physical location at which the coordination of information and resources to support domestic incident management activities normally takes place. An EOC may be located in a permanent or temporary location. EOCs may be organized by major functional disciplines (fire, law enforcement, medical services, etc.), by jurisdiction (Federal, State, regional, county, city, tribal), or by some combination.

**Emergency Responders (medical)**—Disaster Response Force members who deploy after first responders and provide additional support. They include follow on medical personnel including additional ambulances, physicians, nurses, technicians, and other specialized teams. Teams such as radiology, laboratory, pharmacy, surgery, and nutritional medicine would not ordinarily leave the facility and are therefore not considered emergency responders. Examples of MCRP teams in the emergency responder category would be the Field Response Team, Triage Team, the Public Health Team, and the Nursing Services Team.

**Emergency Support Function**—A grouping of government and certain private sector capabilities into an organizational structure to provide the support, resources, program implementation, and services to help communities recover following domestic incidents.

**Federal Coordinating Center (FCC)**—A facility located in a metropolitan area of the United States, and Puerto Rico, responsible for day-to-day coordination of planning and operations in one or more assigned geographic NDMS Patient Reception Areas (PRA). **Note:** The main difference between the FCC and the Primary Receiving Center (PRC) mission is FCCs coordinate planning, training, exercising, and operations of one or more NDMS PRAs. PRCs receive; triage, stage, transport, and track patients affected by a disaster to participating NDMS inpatient hospitals capable of providing the required definitive care.

**Installation Medical Response**—Term that encompasses the full spectrum of installation medical response activities, including medical contingency response, WMD response, MC—CBRN response, home station medical response, defense support to civil authorities, civil support, and disaster response.

**The Joint Commission**—Previously called the Joint Commission on Accreditation of Healthcare Organizations. The name change reflects the Joint Commission's continuing efforts to improve the value of accreditation and its utility as a mechanism for improving the quality and safety of patient care in all organizations.

**Just—In-Time (JIT) Training**—Training that augments core requirements and occurs in conjunction with activities in support of expeditionary and all hazards response operations. Training is normally time sensitive and usually limited to that period of time that immediately precedes the activity, deployment or function.

**Patient Reception Area (PRA)**—A geographic locale containing one or more airfields, bus stations, or airfields; adequate patient staging facilities; and adequate local patient transport assets to support patient reception and transport to pre-identified, non-Federal, acute care NDMS hospitals capable of providing definitive care for victims of a domestic disaster, emergency, or military contingency. Generally, these hospitals are within a 50 mile radius.

**Primary Receiving Center (PRC)**—A Military Treatment Facility (MTF) or VA Medical Center (VAMC) designated for coordinating and/or providing treatment to sick and wounded military personnel returning from armed conflict or national emergency. The main difference between the FCC and the PRC mission is FCC's coordinate planning, training, exercising and operations of one or more NDMS Patient Reception Areas. FCCs receive; triage, stage, transport and track already inpatients affected by a disaster to participating NDMS inpatient hospitals capable of providing the required definitive care. The patients will more than likely not be eligible for care in a Federal treatment facility. The mission of a PRC is to receive and treat sick and wounded military personnel returning from armed conflict or national emergency.

**Patient Reception Team (PRT)**—A multifunction group consisting mainly of clinical staff, but also including appropriate support from medical administration, communications, logistics, litter-bearers, drivers, etc., to support the NDMS mission. The team may consist of military and/or civilian personnel, depending on the local FCC. The mission of the PRT is to receive, sort, triage, and care for patients as they arrive at the PRA awaiting distribution to NDMS hospitals. The PRT regulates and transports patients to area NDMS hospitals and monitors NDMS patients' status, location, care, and costs then assists returning patients back to home or duty station

**Secondary Support Center (SSC)**—Military Treatment Facility (MTF) or VA Medical Center (VAMC) designated to accept transfers from, or sharing resources with, a Primary Receiving Center (DOD or VA Only) to maximize health care services support to the DOD.

**Sustainment Training**—Training required to maintain or enhance the proficiency of individual readiness, clinical, and unit/platform skills.

**Training Cycle**—That period of time, as defined by each service component, in which all mandatory medical readiness training must be completed. The Air Force training cycle currently coincides with the AEF cycle.

**Wound and Casualty Management**—Wound management refers to those medical skills that are needed to care for trauma and disease non battle injury patient conditions. Casualty management refers to those skills that are needed to triage and regulate casualties, to include land and air medical evacuation, and staging.



## Attachment 2

### APPLICATION OF THE LAW OF ARMED CONFLICT

**A2.1. General.** As a matter of Air Force policy, medical personnel may deploy as either noncombatants or combatants. The protections afforded under the Geneva Conventions are different for each category, and therefore, medical personnel should verify their status and the consequences of that status prior to deployment.

**A2.2. Noncombatants.** Medical personnel are considered noncombatants if they are *exclusively engaged* in performing medical duties. This includes supporting duties such as medical records, administration, disease prevention, and the variety of missions performed by Bioenvironmental Engineering personnel for the purposes of prevention of disease/sickness through health risk assessment and control. Noncombatants may carry weapons for self-defense, defense of patients, or defense of other noncombatants such as their co-workers. However, medical personnel may not engage in actions that are harmful to lawful enemy combatants, such as offensive military operations, convoy operations, or laying minefields, without losing their noncombatant status for the duration of their deployment and subjecting themselves to being targeted by the enemy. If captured, true non-combatants are considered *retained personnel* and not *prisoners of war*.

**A2.3. Combatants.** Medical personnel may deploy as combatants and as such are prohibited from appearing as noncombatants while deployed in a combatant capacity. This means that while serving in a combatant role:

A2.3.1. Medical personnel may not wear the large red cross armband.

A2.3.2. Medical personnel may not carry the DD Form 1934, *Geneva Conventions Identification Card*.

A2.3.3. Medical personnel are not entitled to special protection against enemy attacks. (In this scenario, medical personnel are lawful targets.)

A2.3.4. Upon capture, medical personnel in combatant roles are considered *prisoners of war* rather than *retained personnel*. However, the capturing force may elect to use the captured medical personnel in their medical capacity instead. In that event, the medical personnel would be entitled to the same treatment as retained personnel.

**A2.4. Disclaimer.** This section is not intended to answer all of the possible scenarios for medical-legal issues relating to combatants and noncombatants. The Air Force Judge Advocate General should be consulted for answers to specific questions. Also, AF/JAO has published specific legal reviews for medical personnel and those documents should be reviewed (see AF/JAO Memorandums dated 08 Sep 08 at on the AF Medical Readiness SharePoint Site assessable through the AF Portal).

## Attachment 3

## MC-CBRN ALLOWANCE STANDARD REQUIREMENTS

**A3.1. MC-CBRN AS:** The teams listed in Table A3.2 have additional material requirements necessary to support MC-CBRN response capabilities exceeding those provided during normal day-to-day operations. The respective MCRP team chiefs are responsible for maintaining assigned MC-CBRN materiel in accordance with AFI 41-209, *Medical Logistics Support*, and guidance provided by HQ ACC. These assets must be stored in ready status and in locations that are easily accessible during duty and non-duty hours. (T-2) **Note:** Applicable allowance standard packages listed in Table A3.1 below provide a baseline capability which can be tailored based on local mission, vulnerabilities, etc.

**Table A3.1. Unit MC-CBRN Allowance Standards Applicability.<sup>1</sup>**

Allowance Standard	In-patient MTFs	Out-patient MTFs	LS and LSISS MTFs <sup>2</sup>	Air National Guard Non-Collocated Units <sup>3</sup>	Air Force Reserve Non-Collocated Units
886 A	A	A	NA	A – 976A	NA
886 D	A	NA	NA	NA	NA
886 E	A	A	M	NA	NA
886 H	A	A	M	A – 976H	M
886 I	A	A	M	NA	NA
886 J	A	A	M	NA	NA
886 K	A	A	M	A – 976K	NA
886 L	A	A	M	NA	NA
886 M	A	A	NA	NA	NA
886 P	A	A	M	A – 976P	M

**A**= Applicable; unit may determine the need to have the equipment/capability associated with the specified allowance standard or may tailor the allowance standard based on local threat or mission requirements.

**NA**=Not Applicable

**M**= Some level of capability is required. Units may modify assigned 886AS packages with MAJCOM approval in order to provide an appropriate level of capability.

<sup>1</sup> Reference the Medical Resource Letter (MRL) for MC-CBRN AS assignments.

<sup>2</sup> Unless agreements specify that capabilities are not required

<sup>3</sup> ANG 976 packages differ slightly from AC packages.

**Table A3.2. MCRP Teams and Associated Allowance Standards.**

<b>Allowance Standard</b>	<b>Responsible Team Chief</b>	<b>Associated MCRP Team</b>
886A, Patient Decontamination <sup>1</sup>	Patient Decontamination Team Chief	Patient Decontamination Team
886D, Inpatient Medical Follow-on	Nursing Services Team Chief	Nursing Services Team
886E, Pharmacy Response	Pharmacy Team Chief	Pharmacy Team
886H, Bioenvironmental Engineering	Bioenvironmental Engineering Team Chief	Bioenvironmental Engineering Team
886I, Laboratory Biological Detection	Laboratory Team Chief	Laboratory Biological Detection Team
886J, Field Response	Field Response Team Chief	Field Response Team
886K, Triage	Triage Team Chief	Triage Team
886L, Clinical	The Clinical Services (if used) or Immediate Team Chief	Clinical Services Teams (Minimal, Delayed, Immediate)
886M, Medical Manpower/Security <sup>2</sup>	Security Team Chief	Manpower/Security Team
886P, Public Health	Public Health Team Chief	Public Health Team
<p><sup>1</sup> A minimum of 12 trained medical personnel are required to staff the patient decontamination system and perform decontamination. Minimum training requirements are provided in chapter 5. Commanders and team chiefs must ensure sufficient additional personnel are trained as augmentees to perform patient decontamination to allow for continual operations and team member work/rest cycles. The 886A AS has sufficient PPE for up to 24 personnel.</p> <p><sup>2</sup> A Manpower/security decon support team may be established to provide support to the decontamination process if necessary.</p>		

**Table A3.3. ANG Medical Teams and Associated Allowance Standards.**

<b>Medical Team</b>	<b>Responsible Team Chief</b>	<b>Located</b>	<b>Composition</b>
976A, Patient Decontamination <sup>1</sup>	Patient Decontamination Team Chief	at all ANG Non-Collocated units. Collocated units will be assigned to teams under their AD host as needed	1 full-time medical AFSC and 11 full-time non-medical AFSCs
976H, Bioenvironmental Engineering	Bioenvironmental Engineering Team Chief	at all ANG Medical Units who have BE Staff	Full-time Bioenvironmental Engineering Staff
976K, Triage	Triage Team Chief	supplies and materials only	No manpower, material support to responders only
976P, Public Health	Public Health Team Chief	at all ANG Medical Units who have PH Staff	Full-time Public Health Staff